

8526

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist. 08762

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 26

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Carroll</b>		MARYLAND		STATE <b>Maryland</b> COUNTY <b>Carroll</b>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR			
<input checked="" type="checkbox"/> TOWN <b>Rural, Westminster</b>		<b>Life</b>		TOWN <b>Rural, Westminster</b>		<input checked="" type="checkbox"/>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>(Silver Run) Westminster, Md. R.D.1</b>				STREET ADDRESS (If rural, give location) <b>(Silver Run) Westminster, Md. R.D.1</b>			
3. NAME OF DECEASED: (First) <b>Harvey</b>		(Middle) <b>Alvin</b>		(Last) <b>Bankert</b>		4. DATE OF DEATH <b>Sept 22 1955</b>	
5. SEX: <b>Male</b>	6. COLOR OR RACE: <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <b>Married</b>	8. DATE OF BIRTH: <b>August 1, 1872</b>		9. AGE last birthday: <b>83</b> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <b>Farmer, Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY: <b>Own farm</b>		11. BIRTHPLACE (State or foreign country): <b>Carroll Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME: <b>Frederick Bankert</b>				14. MOTHER'S MAIDEN NAME: <b>Julia Koontz</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>No.</b>		16. SOCIAL SECURITY No.: <b>212-24-6461</b>		17. INFORMANT & ADDRESS: <b>Harvey L. Bankert R. D. 1, Westminster, Md.</b>			

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
Immediate cause (a) <b>Coronary Occlusion</b> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause <b>DUE TO</b> stating underlying cause last (c)				<b>Minutes</b>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>M.</b>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <b>James J. March</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>9/22/55</b> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <b>Burial</b>		DATE THEREOF <b>9/25/55</b>		NAME OF CEMETERY OR CREMATORY <b>St. Marys Cemetery</b>	
LOCATION (City, town, or county) (State) <b>Silver Run, Carroll Co., Md.</b>		24. FUNERAL DIRECTOR ADDRESS <b>Littlestown, Pa.</b>			
DATE REC'D BY LOCAL REG. <b>9-23-55</b>		REGISTRAR'S SIGNATURE <b>Harriet Miller</b>		24. FUNERAL DIRECTOR <b>Wm. Little - son</b>	

By O.P.A. Little - Partner

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU A. 8.

## MARYLAND STATE DEPARTMENT OF HEALTH

08528

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 76

8521

1. PLACE OF DEATH - COUNTY <b>Carroll</b>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <b>Maryland</b>		COUNTY <b>Carroll</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Westminster</b>		LENGTH OF STAY (in this place) <b>life</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Westminster</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>173 W. Main Street</b>				STREET ADDRESS (If rural, give location) <b>173 W. Main Street</b>			
3. NAME OF DECEASED (Type or Print) <b>John</b>		(First)		(Middle) <b>Hess</b>		(Last) <b>Belt</b>	
4. DATE OF DEATH <b>September 22, 1955</b>		(Month)		(Day)		(Year)	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Widowed</b>		8. DATE OF BIRTH <b>July 24, 1909</b>	
9. AGE last birthday <b>46</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clergyman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Church</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>John D. Belt</b>		14. MOTHER'S MAIDEN NAME <b>Effie Hess</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>	
16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT AND ADDRESS <b>Mrs. Effie Belt, Westminster, Maryland</b>		18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		(a) <b>590X Immediate cause</b>		(b) <b>Antecedent cause(s)</b>		INTERVAL BETWEEN ONSET AND DEATH	
						<b>16 hours</b>	
						<b>7 days</b>	
11. OTHER SIGNIFICANT CONDITIONS		Conditions contributing to the death but not related to the disease or condition causing death.		19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT (Specify) <b>SUICIDE</b>		PLACE (Home, farm, factory, street, office bldg., etc.) <b>INJURY</b>		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) <b>OF INJURY</b>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>9/21</b> , 19 <b>55</b> , to <b>9/22</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>9/22</b> , 19 <b>55</b> , and that death occurred at <b>2 A.</b> m., from the causes and on the date stated above.							
SIGNATURE <b>Dr. Huetten</b>		(Degree or title)		ADDRESS <b>Westminster, Md.</b>		DATE SIGNED <b>9/22/55</b>	
23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		DATE THEREOF <b>Sept. 24, 1955</b>		NAME OF CEMETERY OR CREMATORY <b>Lutheran Cemetery</b>		LOCATION (City, town, or county) (State) <b>Taneytown, Maryland</b>	
DATE REC'D BY LOCAL REG. <b>9-26-55</b>		REGISTRAR'S SIGNATURE <b>Harriet Miller</b>		24. FUNERAL DIRECTOR <b>C.O. Fuss &amp; Son</b>		ADDRESS <b>Taneytown, Maryland</b>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 28 1955

BUREAU V. 2.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

08529

8527

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Cerro</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>City</u>	
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) <u>Sykesville</u>		LENGTH OF STAY (in this place) <u>5 years 8 mo</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u> <u>18</u> <u>3701.4</u>			
15. HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>				STREET ADDRESS (If rural give location) <u>307 E. Lorraine Ave</u> ✓			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Harold Caywood Botsford</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>9</u> <u>4</u> <u>1955</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>4/7/01</u>	9. AGE last birthday <u>54</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>—</u>		11. BIRTHPLACE (State or foreign country): <u>U. S. A, New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>Manson Botsford</u>				14. MOTHER'S MAIDEN NAME: <u>Mayra Caywood</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>3 no</u>		16. SOCIAL SECURITY NO. <u>218 07 7269</u>		17. INFORMANT & ADDRESS: <u>Hospital records</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>						<u>2 days</u>	
ANTECEDENT CAUSE (B) <u>Syphilitic meningitis encephalitis</u>						<u>years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Arrested Pulmonary tuberculosis</u>						<u>1 year</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Psychosis due to syphilitic meningitis encephalitis</u>							
19A. DATE OF OPERATION: <u>2</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7/11</u> , 19 <u>50</u> , to <u>9/4</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>9/4</u> , 19 <u>55</u> , and that death occurred at <u>11:20</u> P.M., from the causes and on the date stated above.							
SIGNATURE <u>John D. M.D.</u>		M. D. <u>Sykesville, Md</u>		DATE SIGNED <u>9/4/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Sept 6 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>		LOCATION (City, town, or county) (State) <u>Pikesville Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>SEP 6 - 1955</u>		REGISTRAR'S SIGNATURE <u>William J. Tucker</u>		24. FUNERAL DIRECTOR <u>William J. Tucker</u>		ADDRESS <u>North + Pa Ave</u>	

BUREAU V. 2

SEP 9 1955

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

08530

Reg. Dist. No. 7 8

8528

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH- COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>Maryland</b> COUNTY <b>Carroll</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Rural Taneytown</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Rural Taneytown</b>	
LENGTH OF STAY <b>21</b> years		STREET ADDRESS <b>Route #2</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>07</b>		(If rural, give location)	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <b>Mahlon</b> (Middle) <b>Theodore</b> (Last) <b>Brown</b>		(Month) <b>September</b> (Day) <b>18</b> (Year) <b>19 55</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	8. DATE OF BIRTH <b>July 10, 1873</b>
9. AGE last birthday <b>82</b> yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Brown</b>		14. MOTHER'S MAIDEN NAME <b>Mary Eicholtz</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <b>220-03-3544</b>	
17. INFORMANT AND ADDRESS <b>Mrs. Mahlon Brown, Taneytown, Maryland</b>			

## 18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
154X Immediate cause (a) <b>Adenocarcinoma of the rectum</b>		<b>2 yrs.</b>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Chronic myocarditis, Generalized arteriosclerosis, Syn. Early gangrene of feet.</b>		<b>1 year</b>
19a. DATE OF OPERATION <b>2/22/55</b>	19b. MAJOR FINDINGS OF OPERATION <b>Intestinal obstruction due to carcinoma of rectum</b>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **10/5**, 19**40**, to **9/18**, 19**55**, that I last saw the deceased alive on **9/12**, 19**55**, and that death occurred at **3 A.** m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

**R. S. McVaugh M.D.****E.S.T.****Taneytown, Md.****9/19/55**

23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>	DATE THEREOF <b>Sept. 20, 1955</b>	NAME OF CEMETERY OR CREMATORY <b>Lutheran Cemetery</b>	LOCATION (City, town, or county) (State) <b>Taneytown, Maryland</b>
DATE REC'D BY LOCAL REG. <b>Sept 19, 1955</b>	REGISTRAR'S SIGNATURE <b>Ethel M. Mehring</b>	24. FUNERAL DIRECTOR <b>C.O. Fuss &amp; Son, Taneytown, Maryland</b>	

**Local**

MARGIN RESERVED FOR BINDING

VS. A15

RECEIVED

SEP 21 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8529

## CERTIFICATE OF DEATH

08531

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Carroll</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Carroll</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Westminster Rural</i>		LENGTH OF STAY (in this place) <i>2 years</i>		CITY (If outside corporate limits, write RURAL, and give nearest town) <i>Elmow Bridge</i>		TOWN <i>Bridge</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>90 Shrews Nursing Home</i>				STREET ADDRESS (If rural give location) <i></i>			
3. NAME OF DECEASED: (Type or Print)			4. DATE OF DEATH:			5. AGE last birthday:	
(First) <i>ANNIE</i> (Middle) <i>KERNELIA</i> (Last) <i>BUFFINGTON</i>			(Month) <i>Sept</i> (Day) <i>4</i> (Year) <i>1955</i>			IF UNDER 1 YEAR IF UNDER 24 HRS.	
6. SEX: <i>F</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>W</i>		8. DATE OF BIRTH: <i>Jan 1 - 1873</i>		9. AGE last birthday: <i>82</i> yrs. Months Days Hours Min.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY: <i>own home</i>		11. BIRTHPLACE (State or foreign country): <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME: <i>Michael Lippy</i>				14. MOTHER'S MAIDEN NAME: <i>Ellen Myers</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>no</i>		16. SOCIAL SECURITY No.: <i>none</i>		17. INFORMANT & ADDRESS: <i>Clarence Buffington - Westminster Md</i>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
Immediate cause <i>331X Cerebral Hemorrhage</i>						<i>3 days</i>	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. <i>Arterio Sclerosis</i>							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Sept 1</i> , 1955, to <i>Sept 4</i> , 1955, that I last saw the deceased alive on <i>9-4</i> , 1955, and that death occurred at <i>7:15 PM</i> , from the causes and on the date stated above.							
SIGNATURE <i>J. H. Huggins, M.D.</i>				DATE SIGNED <i>9-5-55</i>			
23. BURIAL, CREMATION, REMOVAL (Specify)		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)		(State)	
<i>Burial</i>		<i>Pipe Creek</i>		<i>Carroll Co.</i>		<i>Md</i>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<i>9-6-55</i>		<i>Harriet Miller</i>		<i>W. H. Hutchins &amp; Sons</i>			

RECEIVED

SEP 7 1955

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08532  
8530 CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Carroll</u>	MARYLAND	STATE <u>Md</u>	COUNTY <u>City</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Sykesville</u>	LENGTH OF STAY (in this place) <u>12 hr; 8 mos.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u> <u>38014</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hosp. Cal</u>		STREET ADDRESS (If rural give location) <u>4607 York Road</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE OF DEATH: (Month) (Day) (Year)	
<u>Joseph Wilson Burnett</u>		<u>9 24 1955</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widowed</u>	8. DATE OF BIRTH: <u>April 1877</u>
9. AGE last birthday <u>78</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>unknown</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>unk</u>	11. BIRTHPLACE (State or foreign country): <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME: <u>unknown</u>	
14. MOTHER'S MAIDEN NAME: <u>unknown</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. <u>unk</u>		17. INFORMANT & ADDRESS: <u>Hospital records</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
422.1 IMMEDIATE CAUSE			
ANTECEDENT CAUSE (S):			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(A) <u>Arteriosclerotic cardiovascular disease</u>			<u>years</u>
(B) <u>Generalized arteriosclerosis</u>			<u>years</u>
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>C.B.S. an. with circulatory disturbance cerebral arteriosclerosis with psychomotor retardation</u>			<u>years</u>
19A. DATE OF OPERATION: <u>2</u>		19B. MAJOR FINDINGS OF OPERATION: <u>retardation</u>	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>1/20</u> , 1953, to <u>9/24</u> , 1955 that I last saw the deceased alive on <u>9/24</u> , 1955, and that death occurred at <u>10<sup>35</sup></u> P.M., from the causes and on the date stated above.			
SIGNATURE <u>Gertrude M. Gross, M.D.</u>		ADDRESS <u>Sykesville, Md</u>	DATE SIGNED <u>9/24/55</u>
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>9-27-55</u>	<u>London Park</u>	<u>Baltimore, Md</u>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>Sept. 25, 1955</u>	<u>C. Harry Allen</u>	<u>W. H. Ark. Inc.</u>	<u>12124 Park St. Balto</u>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 30 1955

BUREAU V. 2

STATE OF MARYLAND  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
FACSIMILE OF DEATH CERTIFICATE

NAME OF DECEASED: [illegible]  
AGE: [illegible]  
SEX: [illegible]  
DATE OF BIRTH: [illegible]  
PLACE OF BIRTH: [illegible]  
DATE OF DEATH: [illegible]  
PLACE OF DEATH: [illegible]  
CAUSE OF DEATH: [illegible]  
MANNER OF DEATH: [illegible]  
SIGNATURE OF REGISTRAR: [illegible]  
OFFICIAL SEAL: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
8531 CERTIFICATE OF DEATH

08533  
Reg. Dist. No. 74

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Carroll</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Cecil</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>X Henryton</b>		LENGTH OF STAY (in this place) <b>349 days</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>North East</b>		<b>07X-2</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>03 Henryton, Maryland</b>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last) <b>Laura Carnes</b>		4. DATE OF DEATH: (Month) (Day) (Year) <b>9 5 19 55</b>		5. SEX: 6. COLOR OR RACE: <b>Female Negro</b>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>Widow</b>	
8. DATE OF BIRTH: <b>4-16-1876</b>		9. AGE last birthday: <b>79</b> yrs.		10. USUAL OCCUPATION: Give kind of work done during most of working life, even if retired): <b>Unknown</b>		11. BIRTHPLACE (State or foreign country): <b>Tennessee</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		13. FATHER'S NAME: <b>Louis Barnes</b>		14. MOTHER'S MAIDEN NAME: <b>Unknown</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <b>4 No</b>	
16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <b>Elmow Bailey - North East, Maryland</b>		18. MEDICAL CERTIFICATION		Interval Between Onset And Death	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <b>002X Immediate cause</b> <b>(a) Far advanced bilateral cavitory pulmonary TBC</b> <b>DUE TO</b> <b>Antecedent causes (s)</b> <b>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.</b> <b>(b) DUE TO</b> <b>(c)</b>							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY ? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) <b>INJURY</b>		(CITY OR TOWN) (COUNTY) (STATE)			
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR ?			
22. I hereby certify that I attended the deceased from <b>9-21-</b> 19 <b>54</b> to <b>9-5-</b> 19 <b>55</b> , that I last saw the deceased alive on <b>9-5-</b> 19 <b>55</b> , and that death occurred at <b>Henryton, Maryland</b> from the causes and on the date stated above. SIGNATURE <b>T.F. Vestal, M.D.</b> ADDRESS <b>9-5-55</b>							
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<b>Removal</b>		<b>Sept 9/1955</b>		<b>Baptist</b>		<b>North East Cecil Md</b>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<b>9-5-55</b>		<b>Albert R. Brundham</b>		<b>Joseph R. Gray</b>		<b>North East Md</b>	

RECEIVED

SEP 7 1955

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

08534

2411 N. Charles Street, Baltimore

8532

## CERTIFICATE OF DEATH

Reg. Dist. No. 81

1. PLACE OF DEATH COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Union Bridge</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Int Union</u>		STREET ADDRESS (If rural, give location) <u>Int Union</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>JESSE</u> <u>JOSEPH</u> <u>CARTZENDAFNER</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 18</u> - <u>55</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>12/29/1892</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer-retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>owner</u>	9. AGE last birthday <u>62</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William Cartzendorfner</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Blacksten</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT AND ADDRESS <u>R. B. Cartzendorfner, Union Bridge, Md.</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
422.2 Immediate cause (a) <u>Chronic myocarditis</u>			
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last (b) <u>Infected larynx - same curetted out -</u>		2 wks	
(c) <u>Proctitis, retention.</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)			
SUICIDE HOMICIDE			
TIME (Month) (Day) (Year) (Hour) OF INJURY m. While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>9-2-</u> , 19 <u>55</u> , to <u>9-18-</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>9-17-</u> , 19 <u>55</u> , and that death occurred at <u>8:20 P.</u> m., from the causes and on the date stated above.			
SIGNATURE <u>J. H. Legg M.D.</u> (Degree or title)		ADDRESS <u>Union Bridge, Md.</u> DATE SIGNED <u>9-19-55</u>	
23. BURIAL, CREMATION REMOVAL (Specify) DATE THEREOF <u>9/21/55</u> NAME OF CEMETERY OR CREMATORY <u>St. Ann's Church, Md.</u> LOCATION (City, town, or county) (State) <u>Uniontown, Md.</u>			
DATE REC'D BY LOCAL REG. <u>9/19/55</u> REGISTRAR'S SIGNATURE <u>Julius E. Repp</u>		24. FUNERAL DIRECTOR ADDRESS <u>D. D. Hartzler &amp; Sons, Union Bridge, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

SEP 21 1955

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH

08535

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 70

8533

1. PLACE OF DEATH- COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>Maryland</b> COUNTY <b>Carroll</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Taneytown</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Taneytown</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>60</b>		STREET ADDRESS (If rural, give location) <b>1</b>	
3. NAME OF DECEASED (Type or Print) <b>John Adam Clagett</b>		4. DATE OF DEATH <b>Sept. 17, 1955</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	8. DATE OF BIRTH <b>August 30, 1883</b>
9. AGE last birthday <b>72</b> yrs.		10. If under 1 year Months Days Hours Mln.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>Own farm</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>John A. Clagett</b>	
14. MOTHER'S MAIDEN NAME <b>Annie Hohman</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	
16. SOCIAL SECURITY No. <b>none</b>		17. INFORMANT AND ADDRESS <b>Mrs. J.A. Clagett, Taneytown, Md.</b>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
420.1 Immediate cause (a) <b>Coronary Artery Occlusion</b>		Few Mins.	
Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <b>Coronary Arteriosclerosis</b>		10 yrs.	
(c) <b>Generalized Arteriosclerosis, Chronic Myocarditis &amp; Myocardial Regeneration</b>		10 yrs.	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>2/26</b> , 19 <b>55</b> , to <b>9/17</b> , 19 <b>55</b> that I last saw the deceased alive on <b>9/15</b> , 19 <b>55</b> , and that death occurred at <b>5:45 P.</b> m., from the causes and on the date stated above.			
SIGNATURE <b>R. S. McVaugh</b>		DATE SIGNED <b>9/19/55</b>	
23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		DATE THEREOF <b>Sept. 20, 1955</b>	
NAME OF CEMETERY OR CREMATORY <b>St. Davids Cemetery</b>		LOCATION (City, town, or county) <b>Hanover (Rural)</b>	
24. FUNERAL DIRECTOR <b>C. O. Fuss &amp; Son, Taneytown, Maryland</b>		ADDRESS <b>Penna.</b>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

SEP 21 1955

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH

08536

8522

CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

Reg. Dist. No. 76

1. PLACE OF DEATH- COUNTY <u>Carroll</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Westminster</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Westminster</u> Md. 27-	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cor. Main St &amp; Maryland Ave</u>		STREET ADDRESS (If rural, give location) <u>Const Place</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>CHARLES WESLEY CONAWAY</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Sept. 1 1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>April 8, 1893</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Superintendent</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Schaeffer</u>	9. AGE last birthday <u>62</u> yrs.
13. FATHER'S NAME <u>Henry Conaway</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Schaeffer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>214-03-37354</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Chas. W. Conaway, Westminster, Md.</u>			

18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
420.1 Immediate cause (a) <u>Coronary Occlusion</u>			
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <u>James J. Sharratt, Deputy Medical Examiner - Westminster Md</u>		DATE SIGNED <u>9/1/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Sept. 3. 55</u>	
NAME OF CEMETERY OR CREMATORY <u>Westminster Cemetery Westminster Md.</u>		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REG <u>9-2-55</u>		REGISTRAR'S SIGNATURE <u>Harriet Miller</u>	
24. FUNERAL DIRECTOR <u>J. S. Myers Jr Westminster Md.</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. E.

SEP 6 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8534

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

08537

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Carroll</u> MARYLAND				STATE <u>Maryland</u> COUNTY			
CITY (If outside corporate limits, write RURAL or and give nearest town) TOWN <u>Rural - Sykesville, Md.</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>				STREET ADDRESS (If rural give location) <u>151 113 N. Decker Avenue</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>William James COOKE</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>9</u> <u>7</u> <u>19 55</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>9/2/78</u>	9. AGE last birthday <u>77</u> yrs.	10. UNDER 1 YEAR Months Days	11. UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
13. FATHER'S NAME: <u>William A. Cooke</u>				14. MOTHER'S MAIDEN NAME: <u>Margaret Wilson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT & ADDRESS: <u>Record, Springfield State Hospital</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Bronchopneumonia</u>						days	
ANTECEDENT CAUSE (B) _____							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>CBS associated with senile brain disease, with psychotic react.</u>						years?	
19A. DATE OF OPERATION: <u>2</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8/22</u> , 19 <u>55</u> , to <u>9/7</u> , 19 <u>55</u> that I last saw the deceased alive on <u>9/7/55</u> , 19 <u>55</u> , and that death occurred at <u>9: AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Walter J. Somerville</u>		M.D. <u>Sykesville, Md.</u>		DATE SIGNED <u>9/7/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Sept 10, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Oaklawn Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>9-8-55</u>		REGISTRAR'S SIGNATURE <u>A. N. Shaver</u>		24. FUNERAL DIRECTOR <u>John A. Moran</u>		ADDRESS <u>3000 E. Balto. St.</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible] SEX: [illegible] AGE: [illegible] DATE OF BIRTH: [illegible]

RESIDENCE: [illegible] OCCUPATION: [illegible] CAUSE OF DEATH: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible] SIGNATURE OF DECEASED: [illegible]

SIGNATURE OF WITNESSES: [illegible] SIGNATURE OF MEDICAL OFFICER: [illegible]

DATE OF SIGNATURE: [illegible] PLACE OF SIGNATURE: [illegible]

NAME OF REGISTRAR: [illegible] SIGNATURE OF REGISTRAR: [illegible]

DATE OF REGISTRATION: [illegible] PLACE OF REGISTRATION: [illegible]

NAME OF REGISTRAR: [illegible] SIGNATURE OF REGISTRAR: [illegible]

DATE OF REGISTRATION: [illegible] PLACE OF REGISTRATION: [illegible]

NAME OF REGISTRAR: [illegible] SIGNATURE OF REGISTRAR: [illegible]

DATE OF REGISTRATION: [illegible] PLACE OF REGISTRATION: [illegible]

NAME OF REGISTRAR: [illegible] SIGNATURE OF REGISTRAR: [illegible]

DATE OF REGISTRATION: [illegible] PLACE OF REGISTRATION: [illegible]

NAME OF REGISTRAR: [illegible] SIGNATURE OF REGISTRAR: [illegible]

DATE OF REGISTRATION: [illegible] PLACE OF REGISTRATION: [illegible]

NAME OF REGISTRAR: [illegible] SIGNATURE OF REGISTRAR: [illegible]

DATE OF REGISTRATION: [illegible] PLACE OF REGISTRATION: [illegible]

NAME OF REGISTRAR: [illegible] SIGNATURE OF REGISTRAR: [illegible]

DATE OF REGISTRATION: [illegible] PLACE OF REGISTRATION: [illegible]

NAME OF REGISTRAR: [illegible] SIGNATURE OF REGISTRAR: [illegible]

DATE OF REGISTRATION: [illegible] PLACE OF REGISTRATION: [illegible]

NAME OF REGISTRAR: [illegible] SIGNATURE OF REGISTRAR: [illegible]

DATE OF REGISTRATION: [illegible] PLACE OF REGISTRATION: [illegible]

NAME OF REGISTRAR: [illegible] SIGNATURE OF REGISTRAR: [illegible]

DATE OF REGISTRATION: [illegible] PLACE OF REGISTRATION: [illegible]

NAME OF REGISTRAR: [illegible] SIGNATURE OF REGISTRAR: [illegible]

8535

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08538

Reg. Dist.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 74

## I. PLACE OF DEATH:

COUNTY CARROLL MARYLAND  
 CITY (If outside corporate limits, write RURAL OR and give nearest town) SYKESVILLE LENGTH OF STAY (in this place) 3Y 6M 26 D  
 TOWN RURAL - SYKESVILLE  
 HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MARYLAND COUNTY GARRETT  
 CITY (If outside corporate limits write RURAL and give nearest town) Grantsville  
 TOWN Grantsville  
 STREET ADDRESS (If rural, give location) 11X-2  
 ADDRESS ✓

## 3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

NATHANCUSTER

## 4. DATE OF DEATH

(Month)

(Day)

(Year)

9251955

## 5. SEX:

## 6. COLOR OR RACE:

## 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

## 8. DATE OF BIRTH:

## 9. AGE last birthday:

## IF UNDER 1 YEAR IF UNDER 24 HRS.

MaleWhitesingle2/3/8174747474747474

## 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):

## 10b. KIND OF BUSINESS OR INDUSTRY:

## 11. BIRTHPLACE (State or foreign country):

## 12. CITIZEN OF WHAT COUNTRY?

Farmer and U. MessengerCommunicationsMarylandUSA

## 13. FATHER'S NAME:

## 14. MOTHER'S MAIDEN NAME:

Michael CusterMaria Ferren

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

## 16. SOCIAL SECURITY No.:

## 17. INFORMANT &amp; ADDRESS:

212-24-0754Record, Springfield State Hospital

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

## INTERVAL BETWEEN ONSET AND DEATH

## Immediate cause

(a) Carcinoma of the prostate with metastases to the skull and vertebral bodiesunknown

## Antecedent cause(s)

(b) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(c)

## II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

Chronic brain syndrome associated with cerebral arteriosclerosis, with psychosissince 1948?

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDING OF OPERATION:

## 20. AUTOPSY?

Yes ☒ No ☐21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING CAUSE OF DEATH ☐

## 21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY

## 21c. (City or town)

## (County)

## (State)

## 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED While at work ☐ Not while at work ☒

## 21f. HOW DID INJURY OCCUR?

Patient fell from chair 8/20/55 and from wheel chair on 9/13/5522. I hereby certify that I took charge of the remains described above, held an Autopsy ☐ , Inspection ☒ , Inquiry ☐ , and find that death resulted from: Natural causes ☐ , Accident ☐ , Suicide ☐ , Homicide ☐ , Undetermined cause ☐ .

## SIGNATURE

## CHIEF MEDICAL EXAMINER

## DATE SIGNED

James J. Newman

M. D. DEPUTY MEDICAL EXAMINER

9/26/55

## 23. BURIAL, CREMATION, REMOVAL (Specify):

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

## (State)

## DATE REC'D BY LOCAL REG.

## REGISTRAR'S SIGNATURE

## A. FUNERAL DIRECTOR

## ADDRESS

Sept. 27, 1955C. Henry EckenDonald J. Newman GRANTSVILLE, MD

MARGIN RESERVED FOR BINDING

BUREAU V. S.

SEP 30 1955

RECEIVED

8536

## CERTIFICATE OF DEATH

Reg. Dist. No. 50

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Carroll</i>		MARYLAND		STATE <i>Maryland</i> COUNTY <i>Carroll</i>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
X <i>New Windsor</i>		<i>years</i>		X <i>New Windsor</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<i>Church St</i>				<i>Church St</i>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<i>MARY GOLDIE DANNER</i>				OF DEATH: <i>Sept 27 1955</i>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<i>F</i>	<i>W</i>	<i>W</i>	<i>July 6-1883</i>	<i>72</i> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<i>housewife</i>		<i>own home</i>		<i>Maryland</i>		<i>USA</i>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<i>Pius Babylon</i>				<i>Missouri Rinehart</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.		17. INFORMANT & ADDRESS:	
<i>no</i>				<i>220-26-0207</i>		<i>Mrs Russell Lambert, New Windsor</i>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
174X IMMEDIATE CAUSE (A) <i>Metastatic Carcinoma</i>						<i>8 mos.</i>	
ANTECEDENT CAUSE (S) DUE TO (B) <i>Carcinoma Uterus</i>						<i>7 yrs</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<i>0</i>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Jan</i> , 1955, to <i>Sept 27</i> , 1955, that I last saw the deceased alive on <i>Sept 26</i> , 1955, and that death occurred at <i>10:30</i> P.M. from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<i>James J. Thorne</i>		<i>Westminster Md</i>		<i>9/27/55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>Sept 30-1955</i>		<i>Winters Ceme.</i>		<i>Carroll Co Md</i>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<i>Sept 26/55</i>		<i>Conrad B. Broughel</i>		<i>DD Hartley &amp; Sons, New Windsor, Md</i>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 30 1955

BUREAU V. B.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8538

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08541

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Kensington</u> <u>15X-2</u>			
X TOWN <u>Sykesville</u>		<u>2 years</u>		STREET ADDRESS (If rural give location) <u>10700 Montgomery Avenue</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>							
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH: <u>Sept. 12 19 55</u>			
<u>Virginia O. Dawson</u>							
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>2-12-60</u>	9. AGE last birthday <u>95</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Clerk</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>unk -</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>James Madison Dawson</u>				14. MOTHER'S MAIDEN NAME: <u>Louise Hebron</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No.</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>unk</u>		17. INFORMANT & ADDRESS: <u>Hospital records</u>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE <u>332X</u>							
ANTECEDENT CAUSE (S):							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) <u>Cerebral Thrombosis</u>						<u>hours</u>	
(B) <u>Cerebral arteriosclerosis</u>						<u>years</u>	
(C) <u>Generalized arteriosclerosis</u>						<u>years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Chronic Brain syndrome with psych. reaction</u>						<u>years</u>	
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2-19</u> , 19 <u>53</u> to <u>9-12</u> , 19 <u>55</u> that I last saw the deceased alive on <u>9-12</u> , 1955, and that death occurred at 5:45PM, from the causes and on the date stated above.							
SIGNATURE <u>Wilfred Sommerfeld M.D., Springfield State Hospital Sykesville, Md.</u>		ADDRESS <u>Springfield State Hospital Sykesville, Md.</u>		DATE SIGNED <u>9-12-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>9-14-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Monocacy Cemetery</u>		LOCATION (City, town, or county) (State) <u>Beallville, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Sept. 13, 1955</u>		REGISTRAR'S SIGNATURE <u>C. H. H. H. H.</u>		24. FUNERAL DIRECTOR <u>Robert D. Perryman</u>		ADDRESS <u>Bethesda, Md.</u>	

BUREAU V. 2

SEP 15 1955

RECEIVED

8539

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Carroll</u>	MARYLAND	STATE <u>Maryland</u>	CITY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Sykesville</u>	LENGTH OF STAY (in this place) <u>3 y 3 m 21 d</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 14</u>	TOWN <u>3 y 0 1 - 4</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>		STREET ADDRESS (If rural give location) <u>3132 Harview Avenue,</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE OF DEATH: (Month) (Day) (Year)	
<u>Alvina CALBINAD De Ruggiero</u>		<u>9 10 19 55</u>	
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>2-21-99</u>
9. AGE last birthday: <u>56</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>unknown</u>	
13. FATHER'S NAME: <u>Benny De Ruggie</u>		14. MOTHER'S MAIDEN NAME: <u>Fanny Annosico</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>unkn</u>		16. SOCIAL SECURITY No.: <u>unkn</u>	
17. INFORMANT & ADDRESS: <u>Hospital Records</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death	
<u>525X</u> Immediate cause (a) <u>Pneumonia chronic interstitial</u>		<u>6 weeks</u>	
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>DUE TO</u>			
(c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: <u>Involuntional psychosis, depressed type with organic features, possibly with Pick's disease</u>			
19a. DATE OF OPERATION: <u>0</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>July 18, 19 55</u> , to <u>Septemb. 10 19 55</u> , that I last saw the deceased alive on <u>9 - 10 -</u> , 1955, and that death occurred at <u>10:25 a.m.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Edmund J. Luthans</u>		ADDRESS <u>Springfield State Hospital</u>	
DATE SIGNED <u>9-10-55</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (city, town, or county) (State)
<u>BURIAL</u>	<u>9/13/55</u>	<u>BELAIR MEMORIAL</u>	<u>BELAIR MD</u>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>9-13-55</u>	<u>R. W. Hedrick</u>	<u>John J. Connelly</u>	<u>Essex 21 Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

— — —

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08543

8540

## CERTIFICATE OF DEATH

Reg. Dist. No. 71

1. PLACE OF DEATH- COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>Maryland</b> COUNTY <b>Carroll</b>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Uniontown</b>				CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Uniontown</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED (Type or Print)		(First)		(Middle)		(Last)	
		<b>Hilda</b>		<b>E.</b>		<b>Devilbiss</b>	
4. DATE OF DEATH		(Month)		(Day)		(Year)	
		<b>Sept.</b>		<b>2,</b>		<b>19 55</b>	
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
<b>F</b>		<b>W</b>		<b>Married</b>		<b>Feb. 3, 1900</b>	
9. AGE last birthday		If under 1 year		If under 24 hrs.		If under 24 hrs.	
<b>55 yrs.</b>		Months		Days		Hours	
						Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<b>housewife</b>				<b>own home</b>		<b>Maryland</b>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<b>Franklin Eckard</b>				<b>Carrie S. Yingling</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY No.		17. INFORMANT AND ADDRESS	
<b>no</b>				<b>none</b>		<b>Thomas L. Devilbiss, Uniontown, Maryland</b>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
260X Immediate cause (a) <b>Cerebral hemorrhage</b>						<b>12 hrs</b>	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <b>Diabetes - Nephritis arterio-sclerotic</b>							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
SUICIDE		INJURY					
HOMICIDE							
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED		HOW DID INJURY OCCUR?			
OF INJURY		While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <b>9-2-</b> , 19 <b>55</b> , to <b>9-2-</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>9-2-</b> , 19 <b>55</b> , and that death occurred at <b>2:45 P.</b> m., from the causes and on the date stated above.							
SIGNATURE <b>J. N. Legg M.D.</b>				ADDRESS <b>Uniontown, Maryland</b>		DATE SIGNED <b>9-3-55</b>	
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<b>burial</b>		<b>Sept. 5, 1955</b>		<b>Lutheran Cemetery</b>		<b>Uniontown, Maryland</b>	
DATE REC'D BY LOCAL REG. <b>9/4/55</b>		REGISTRAR'S SIGNATURE <b>Margaret R. Englar</b>		24. FUNERAL DIRECTOR		ADDRESS	
				<b>C.O. Fuss &amp; Son, Taneytown, Maryland</b>			

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 7 1955

BUREAU V. S.

8523

## CERTIFICATE OF DEATH

Reg. Dist. No. 76

## 1. PLACE OF DEATH:

COUNTY Carroll MARYLAND  
 CITY (If outside corporate limits, write RURAL OR and give nearest town) Westminster LENGTH OF STAY (in this place) 1 mo.  
 HOSPITAL OR INSTITUTION OR STREET ADDRESS 88 E. Main

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE md. COUNTY Carroll  
 CITY (If outside corporate limits, write RURAL and give nearest town) Westminster OR TOWN 27  
 STREET ADDRESS (If rural give location) Webster Street

3. NAME OF DECEASED: (First) (Middle) (Last)  
 (Type or Print) CECELIA JOSEPHINE FOWLER

4. DATE OF DEATH: (Month) (Day) (Year)  
Sept. 27 1955

5. SEX: F 6. COLOR OR RACE: W 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single 8. DATE OF BIRTH: March 12-1873 9. AGE last birthday: 82 yrs. Months Days Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: Ret. Seamstress 10b. KIND OF BUSINESS OR INDUSTRY: Maryland 11. BIRTHPLACE (State or foreign country): U.S.A 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Andrew Fowler 14. MOTHER'S MAIDEN NAME: Catherine L. Ooby

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service) 16. SOCIAL SECURITY No.: none 17. INFORMANT & ADDRESS: Mr. Joseph Manger Jr. 99 E. Main Westminster, Md.

## 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  
442X  
 Immediate cause (a) Cardio Vascular Renal Disease  
 Antecedent causes (s) DUE TO decompensation  
 Diseases or conditions, if any, giving rise to the above cause (b) arterio sclerosis renal  
 stating the underlying cause last. DUE TO & senility  
 (c)

Interval Between Onset And Death

Several  
hrs  
5 yrs

11. OTHER SIGNIFICANT CONDITIONS  
 Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY ?

Yes ☐ No ☐

21. ACCIDENT (Specify) PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)  
 SUICIDE  
 HOMICIDE

TIME (Month) (Day) (Year) (Hour) INJURY OCCURRED HOW DID INJURY OCCUR ?  
 OF While at Not While  
 INJURY m. Work ☐ At Work ☐

22. I hereby certify that I attended the deceased from Sept 28, 1955, to Sept 29, 1955, that I last saw the deceased alive on Sept 28, 1955, and that death occurred at Westminster Md, from the causes and on the date stated above.  
 SIGNATURE William Speischer ADDRESS Westminster Md DATE SIGNED Sept 29-1955  
 (Degree or title)

23. BURIAL, CREMATION, REMOVAL (Specify) DATE THEREOF NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State)  
Burial Sept. 30, 1955 St. John's Cemetery Westminster md.  
 DATE REC'D BY LOCAL REGISTRAR REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR ADDRESS  
9-28-55 Haniet Miller P. Bankard P.O. Box Westminster, Md.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 30 1955

BUREAU V. B.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08545

8541

## CERTIFICATE OF DEATH

Reg. Dist. No. 70

1. PLACE OF DEATH- COUNTY <b>Carroll</b>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>Maryland</b>		COUNTY <b>Carroll</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Taneytown</b>		LENGTH OF STAY (in this place) <b>19 years</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Taneytown</b>		<b>X</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>05</b>				STREET ADDRESS <b>3 Frederick Street</b>		<b>1</b>	
3. NAME OF DECEASED (Type or Print)		(First)		(Middle)		(Last)	
<b>Sarah</b>		<b>E.</b>		<b>Frock</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>September 23, 1955</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Widow</b>	8. DATE OF BIRTH <b>Nov. 27, 1880</b>	9. AGE last birthday <b>74</b> yrs.	If under 1 year Months   Days   Hours   Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Emanuel Fink</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Snyder</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT AND ADDRESS <b>Mr. Carel Frock, Taneytown, Maryland</b>	

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

204.1 Immediate cause (a) **Cerebral Hemorrhage** **2 days**

Antecedent cause(s) (b) **Chronic myelogenous leukemia** **2 years**

(c)

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.**Generalized Arteriosclerosis****10 yrs.**

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **March 9, 1954**, to **Sept 23, 1955**, that I last saw the deceased alive on **Sept 23, 1955**, and that death occurred at **10:50 p.m.**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		DATE THEREOF <b>Sept. 26, 1955</b>		NAME OF CEMETERY OR CREMATORY <b>Reformed Cemetery</b>		LOCATION (City, town, or county) (State) <b>Taneytown, Maryland</b>	
DATE REC'D BY LOCAL REG. <b>Sept 26/55</b>		REGISTRAR'S SIGNATURE <b>Ethel M. Mehning</b>		24. FUNERAL DIRECTOR <b>C.O. Fuss &amp; Son, Taneytown, Maryland</b>		ADDRESS	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 2

SEP 28 1955

RECEIVED

8542

## CERTIFICATE OF DEATH

Reg. Dist. No. 75

## 1. PLACE OF DEATH:

COUNTY

Carroll

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)

x TOWN Manchester

LENGTH OF STAY (in this place)

37w

HOSPITAL OR INSTITUTION OR STREET ADDRESS

Park are extended

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

COUNTY

Carroll

CITY (If outside corporate limits, write RURAL and give nearest town) OR

TOWN Manchester x

STREET ADDRESS (If rural, give location)

Park are extended

## 3. NAME OF DECEASED:

(First)

(Middle)

(Last)

William F. Gehardt Sr.

4. DATE

(Month)

(Day)

(Year)

OF

DEATH:

9-3-1953

## 5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH:

9. AGE last birthday:

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

## 13. FATHER'S NAME:

## 14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT &amp; ADDRESS:

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

180X

Immediate cause

(a)

DUE TO

Renal Carcinoma

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b)

DUE TO

Arteriosclerosis

(c)

pulmonary Emphysema

INTERVAL BETWEEN ONSET AND DEATH

1 yr

5 yrs

15 yrs

## II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION:

## 20. AUTOPSY?

Yes ☐ No ☐

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Dny) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Not while work ☐ at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 1952, to Sept 3, 1955, that I last saw the deceased alive on Sept 1, 1955, and that death occurred at 10:35 P.m., from the causes and on the date stated above.

SIGNATURE

(DEGREE OR TITLE) ADDRESS

DATE SIGNED

W H Foard

M.D.

Manchester Md

9/6/55

## 23. BURIAL, CREMATION REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE RECD BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Sept 6/55

Mr. W. P. Demmer

Frederick Bucher Hanover Pa

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

SEP 16 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8543

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 08547

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>md.</u>		COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Johnsville</u>		LENGTH OF STAY (in this place) <u>54 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Johnsville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>				STREET ADDRESS (If rural give location) <u>Lykensville P.O.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Lillie Irene Gosnell</u>				4. DATE (Month) (Day) (Year) OF DEATH <u>Sept. 30 1955</u>			
5. SEX: <u>St.</u>	6. COLOR OR RACE: <u>Col.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>3-2-1880</u>	9. AGE last birthday <u>75</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Home</u>		11. BIRTHPLACE (State or foreign country): <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Henry Jackson</u>				14. MOTHER'S MAIDEN NAME: <u>Harriet Spriggs</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS: <u>Robert Gosnell, Lykensville, md.</u>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>443X Hypertensive cardiovascular disease</u>						<u>several years</u>	
ANTECEDENT CAUSE (B) <u>chr. atherosclerosis &amp; chr. myocarditis</u>						<u>several years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>senile changes</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Transition</u>						<u>3-4 mos</u>	
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1935</u> , 19 <u>  </u> , to <u>30 Sept, 1955</u> , that I last saw the deceased alive on <u>29 Sept, 1955</u> , and that death occurred at <u>9:45 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>St. Lawrence</u>		M. D. <u>Lykensville, md.</u>		DATE SIGNED <u>30 Sept-1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10-3-55</u>		NAME OF CEMETERY OR CREMATORY <u>Johnsville</u>		LOCATION (City, town, or county) (State) <u>Carroll Co., md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Sept. 30, 1955</u>		REGISTRAR'S SIGNATURE <u>C. Henry Allen</u>		24. FUNERAL DIRECTOR <u>Arthur H. Wright - Lykensville, md.</u>		ADDRESS	

CERTIFICATE OF DEATH

1. Name of deceased

2. Sex

3. Age

4. Date of birth

5. Place of birth

6. Date of death

7. Place of death

8. Cause of death

9. Date of funeral

10. Place of funeral

11. Name of funeral home

12. Name of physician

13. Name of undertaker

14. Name of cemetery

15. Name of church

16. Name of minister

17. Name of sexton

18. Name of registrar

19. Name of clerk

20. Name of assistant

21. Name of janitor

22. Name of porter

23. Name of messenger

24. Name of watchman

25. Name of night watchman

26. Name of janitor

27. Name of porter

28. Name of messenger

29. Name of watchman

30. Name of night watchman

BUREAU V. S.

OCT 5 1955

RECEIVED

8544

MARYLAND STATE DEPARTMENT OF HEALTH

08548

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Item 18 Film G186 9-16-55 ams

Reg. Dist. No. 16

1. PLACE OF DEATH- COUNTY <u>Carroll</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural Westminster</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural Westminster</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>P.D. 4</u>		STREET ADDRESS <u>P.D. 4</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>EMMA</u> (Middle) <u>MAY</u> (Last) <u>HAINES</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Sept. 3 1955</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Oct. 13, 1886</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>68</u> yrs. If under 1 year Months Days If under 24 hrs Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Samuel F. Fritz</u>		14. MOTHER'S MAIDEN NAME <u>Sarah S. Limmer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>214-16-1730</u>	
17. INFORMANT AND ADDRESS <u>Viola Brown Westminster Md.</u>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
1. Immediate cause (a) <u>Undetermined</u>		
Antecedent cause(s) (b) <u>Obstructive lesion of Cord at T8</u>		<u>month</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>unknown</u>		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>Sept. 6, 1955</u>	<u>Locust Grove Cem.</u>	<u>Fred. Co.</u>	<u>Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>9-4-55</u>	<u>Samuel Miller</u>	<u>A. Bancroft</u>	<u>Rural Westminster, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 7 1935

BUREAU V. S.

8545

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08549

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Carroll</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>---</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) X TOWN <u>Sykesville (Rural)</u>	LENGTH OF STAY (in this place) <u>since 6/8/07</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore City</u>	<u>3101.4</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 <u>Springfield State Hospital</u>		STREET ADDRESS (If rural give location) <u>2526 Boarman Avenue</u>	✓
3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) <u>Joseph</u> <u>-</u> <u>HANAN</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>September 22 1955</u>	
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>single</u>	8. DATE OF BIRTH: <u>1879</u>
9. AGE last birthday: <u>76</u> yrs.		10. IF UNDER 1 YEAR: Months <u>---</u> Days <u>---</u> Hours <u>---</u> Min. <u>---</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>none</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>---</u>	
11. BIRTHPLACE (State or foreign country): <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME: <u>James H. Hanan</u>		14. MOTHER'S MAIDEN NAME: <u>Dellia Frost</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service) <u>---</u>		16. SOCIAL SECURITY No. <u>unknown none</u>	
17. INFORMANT & ADDRESS: <u>Records of Springfield State Hospital</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Aspiration pneumonia</u>			<u>5 days</u>
ANTECEDENT CAUSE (S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(B) DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>catatonic schizophrenia</u>			<u>50 years</u>
19A. DATE OF OPERATION: <u>---</u>		19B. MAJOR FINDINGS OF OPERATION: <u>---</u>	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, street, office bldg., etc.) <u>---</u>	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? <u>---</u>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: <u>---</u> M.	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? <u>---</u>	
22. I hereby certify that I attended the deceased from <u>Sept. 1 1947</u> , to <u>Sept. 22 1955</u> , that I last saw the deceased alive on <u>Sept. 22, 1955</u> , and that death occurred at <u>12:34 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Martin Gross</u>		P.M. ADDRESS <u>12. D. Martin Gross, M. D. Sykesville, Md.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Sept 24-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cemetery</u>		LOCATION (City, town, or county) (State) <u>Ritchie Highway A &amp; Co Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>September 23, 1955</u>		24. FUNERAL DIRECTOR <u>Bernard A Fink</u>	
REGISTRAR'S SIGNATURE <u>C. Harry Thiers</u>		ADDRESS <u>Glen Burne Md</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

RECEIVED

SEP 28 1955

BUREAU V. 8



RECEIVED

SEP 30 1955

BUREAU V. 51

8547

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Carroll</u> MARYLAND		STATE <u>Maryland</u> COUNTY <u>Garrett</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Rural - Sykesville</u> LENGTH OF STAY (in this place) <u>since 3/26/53</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural - Kitzmiller</u> <u>11X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>		STREET ADDRESS (If rural give location) <u>---</u>	
3. NAME OF DECEASED: (First) <u>Harry</u> (Middle) <u>-</u> (Last) <u>HERSHBERGER</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Sept. 7</u> <u>1955</u>	
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>	8. DATE OF BIRTH: <u>unknown</u>
9. AGE last birthday <u>79 ?</u> yrs.		IF UNDER 1 YEAR: Months <u>---</u> Days <u>---</u> Hours <u>---</u> Min. <u>---</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>unknown - retired</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>unk.</u>	
11. BIRTHPLACE (State or foreign country): <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME: <u>John S. Hershberger</u>		14. MOTHER'S MAIDEN NAME: <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>yes</u> (If Yes, give war or dates of service) <u>Spanish-American</u>		16. MEDICAL RECORD NO. <u>220-10-10954</u>	
17. INFORMANT & ADDRESS: <u>Records of Springfield State Hospital</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Bronchopneumonia</u>		<u>4 days</u>	
ANTECEDENT CAUSE (S) (B) <u>Arteriosclerosis</u>		<u>more than 9 yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>---</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Senile brain disease</u>		<u>more than 3 yrs.</u>	
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 3, 1953</u> , to <u>Sept. 6, 1955</u> , that I last saw the deceased alive on <u>Sept. 6, 1955</u> , and that death occurred at <u>1:25A</u> M, from the causes and on the date stated above.			
SIGNATURE <u>Martin Gross, M.D.</u>		ADDRESS <u>Sykesville, Maryland</u> DATE SIGNED <u>9/7/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>9-10-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Blaine</u>		LOCATION (City, town, or county) (State) <u>Blaine, W. Va.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Sept. 8, 1955</u>		REGISTRAR'S SIGNATURE <u>C. Harry W...</u>	
24. FUNERAL DIRECTOR <u>W. F. ...</u>		ADDRESS <u>Blaine, W. Va.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

SEP 13 1955

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8548

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08552

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>CARROL</u> MARYLAND				STATE <u>Md</u> COUNTY			
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) <u>Sykesville - 1 1/2 hours 2 1/2 days</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore City 3101.4</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hosp.</u>				STREET ADDRESS (If rural give location) <u>6000 Belkona Avenue</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>ANNA Hess (Hessa)</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>9 - 24 - 1955</u>			
5. SEX: <u>Fe</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widow</u>	8. DATE OF BIRTH: <u>7-7-39</u>	9. AGE last birthday: <u>76</u> yrs.	10. IF UNDER 1 YEAR: <u>2</u> Months	11. IF UNDER 24 MRS. <u>17</u> Hours	12. IF UNDER 24 MRS. <u>-</u> Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>House keeper</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Home</u>		11. BIRTHPLACE (State or foreign country): <u>Md.</u>	
13. FATHER'S NAME: <u>Frank Myers</u>				14. MOTHER'S MAIDEN NAME: <u>Margaret Myers</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) If Yes, give war or dates of service: <u>4 No</u>				16. SOCIAL SECURITY NO. <u>Unk.</u>		17. INFORMANT & ADDRESS: <u>Mrs. Anthony Atman - 2413 Pelham Ave.</u>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
331 X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage sec to Ar -</u>							2 days
ANTECEDENT CAUSE (B) <u>Due to Arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Due to</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>CBS associated with Arteriosclerosis</u>							
19A. DATE OF OPERATION: <u>0</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>3-3-</u> , 19 <u>54</u> , to <u>9-24</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>9-24</u> , 19 <u>55</u> , and that death occurred at <u>6:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Walter H. Jannet</u>				M. D. <u>Sykesville, Md</u> DATE SIGNED <u>9-24-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>9-27-55</u>		NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Sept. 25, 1955</u>		REGISTRAR'S SIGNATURE <u>C. Henry W...</u>		24. FUNERAL DIRECTOR ADDRESS <u>Donald J. Ruck 5305 Harford Rd. Balt.</u>			

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Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

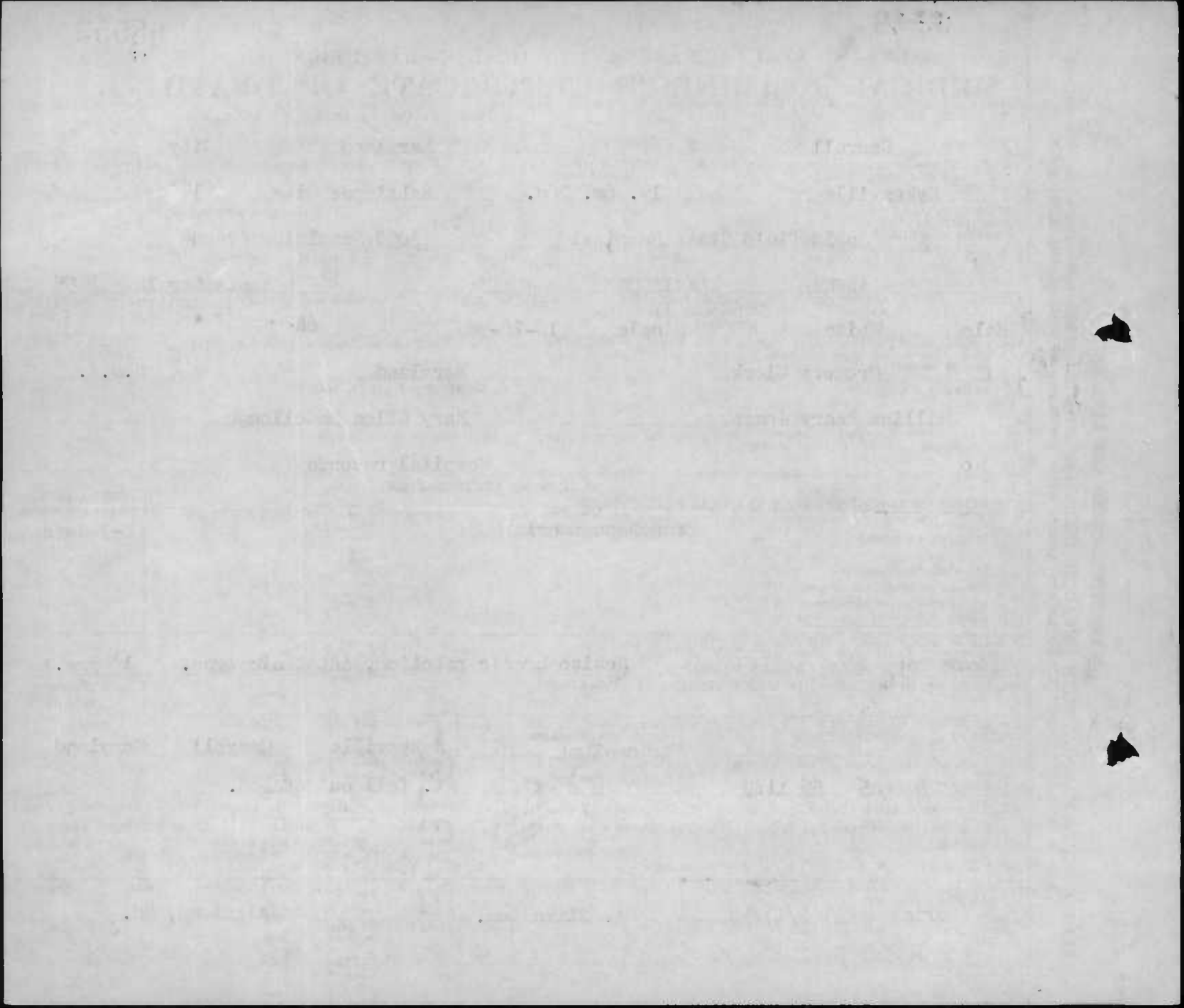
No. 74

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Carroll</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>City</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>X</u> TOWN <u>Sykesville</u>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Baltimore City</u> (15) <u>3V01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>		STREET ADDRESS (If rural, give location) <u>3053 Spaulding Avenue</u>	
3. NAME OF DECEASED: (Type or Print)	(First) <u>ALFRED</u>	(Middle) <u>DAVIDSON</u>	(Last) <u>JONES</u>
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>10-26-90</u>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Grocery Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY:	9. AGE last birthday: <u>64</u> yrs.
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>William Henry Jones</u>		14. MOTHER'S MAIDEN NAME: <u>Mary Ellen McCullough</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No.: <u>Hospital records</u>	
17. INFORMANT & ADDRESS:			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
<u>902.7</u> Immediate cause (a) <u>Bronchopneumonia</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>Schizophrenic reaction, catatonic type.</u>		<u>2-3 days</u>
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION: <u>8 5 55 11:15</u>		19b. MAJOR FINDING OF OPERATION:
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>Hospital</u> )	21c. (City or town) (County) (State) <u>Sykesville Carroll Maryland</u>
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>8 5 55 11:15</u>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Pt. fell out of bed.</u>
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . SIGNATURE <u>James J. Thayer</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>9/15/53</u> M. D. DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>		
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF <u>9/17/55</u>	NAME OF CEMETERY OR CREMATORY <u>Mt. Olive Cem.</u>
LOCATION (City, town, or county) (State) <u>Randallstown, Md.</u>	24. FUNERAL DIRECTOR <u>Wm. J. Siskner</u>	
DATE REC'D BY LOCAL REG. <u>Sept 16, 1955</u>	REGISTRAR'S SIGNATURE <u>Wm. J. Siskner</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



8550

09633  
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** No. 74

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Carroll</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>X</u> TOWN <u>Rural - Sykesville</u>	LENGTH OF STAY (in this place) <u>11 Y 4 M 13 D</u>	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Baltimore</u>	<u>3W 14</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>		STREET ADDRESS (If rural, give location) <u>1018 East Hoffman Street ?</u> ✓	
3. NAME OF DECEASED: (Type or Print)	(First) <u>Anna</u>	(Middle) <u>Mary</u>	(Last) <u>KAY</u>
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>6/13/84</u>
9. AGE last birthday: <u>71</u> yrs.		4. DATE OF DEATH: (Month) <u>9</u> (Day) <u>29</u> (Year) <u>19 55</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>unk</u>	11. BIRTHPLACE (State or foreign country): <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME: <u>Richard L. Kay</u>	
14. MOTHER'S MAIDEN NAME: <u>Nelly Norris</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>unk</u>	
16. SOCIAL SECURITY No.: <u>unk</u>		17. INFORMANT & ADDRESS: <u>Record, Springfield State Hospital</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
<u>331X</u> Immediate cause (a) <u>Bronchopneumonia</u> DUE TO Antecedent cause(s) (b) <u>Cerebral hemorrhage, right, lenticulo-striate artery</u> Diseases or conditions, if any, giving rise to the above cause DUE TO <u>902</u> stating underlying cause last (c) <u>20 days</u>		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Chronic brain syndrome associated with cerebral arteriosclerosis</u>		<u>12 years</u>
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>hospital</u>	21c. (City or town) (County) (State) <u>Sykesville Carroll Maryland</u> <u>06</u>
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>9 9 55 6:30 PM</u>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Patient fell from chair striking left chin</u>
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
SIGNATURE <u>James J. Sharrack</u> M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>9/29/55</u>		
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF <u>10-6-55</u>	NAME OF CEMETERY OR CREMATORY <u>Springfield Hosp. Sykesville, Md</u>
DATE REC'D BY LOCAL REG. <u>Oct. 6, 1955</u>	REGISTRAR'S SIGNATURE <u>C. Harry Tour</u>	24. FUNERAL DIRECTOR <u>Arthur A. Wright - Sykesville, Md.</u> ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
OCT 18 1955  
BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8551

## CERTIFICATE OF DEATH

Reg. Dist. No. 08554

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Carroll</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Sykesville</i>		LENGTH OF STAY (in this place) <i>1 mo 15 days</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Baltimore</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Springfield State Hospital</i>				STREET ADDRESS (If rural give location) <i>3329 Elmore Ave Balto 13 Md.</i>			
3. NAME OF DECEASED: (First) <i>Frances</i> (Middle) <i>R.</i> (Last) <i>Klaumeyer</i>				4. DATE (Month) (Day) (Year) OF DEATH: <i>9. 15 19 55</i>			
5. SEX: <i>Female</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Widowed</i>	8. DATE OF BIRTH: <i>1-1-1865</i>	9. AGE last birthday <i>90</i> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>none</i>			10B. KIND OF BUSINESS OR INDUSTRY: <i>none</i>		11. BIRTHPLACE (State or foreign country): <i>Kansas</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME: <i>not known</i>				14. MOTHER'S MAIDEN NAME: <i>not known</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>if in</i>			16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT & ADDRESS: <i>Hospital records</i>		
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <i>420.0</i>							
(A) DUE TO <i>Coronary occlusion</i>						<i>minutes</i>	
ANTECEDENT CAUSE (B) DUE TO <i>arteriosclerotic heart disease</i>						<i>unknown</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <i>Generalized arteriosclerosis</i>						<i>unknown</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>C.B.S. associated with aortic aneurysm, disease of the sympathetic nervous system, fracture of left hip.</i>						<i>years 2 1/2 months</i>	
19A. DATE OF OPERATION: <i>0</i>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>7-30-1955</i> to <i>9-15-1955</i> that I last saw the deceased alive on <i>9-14-1955</i> , and that death occurred at <i>12:10 AM</i> , from the causes and on the date stated above.							
SIGNATURE <i>Halbur H. Bunnickfeldt</i>		M. D. <i>Springfield State Hospital</i>		ADDRESS <i>Balto. County, Md.</i>		DATE SIGNED <i>9/15/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>9-17-55</i>		NAME OF CEMETERY OR CREMATORY <i>Oakland Cem.</i>		LOCATION (City, town, or county) (State) <i>Balto. County, Md.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>Sept. 20, 1955</i>		REGISTRAR'S SIGNATURE <i>C. Harry [unclear]</i>		24. FUNERAL DIRECTOR ADDRESS <i>Fowler Funeral Home, Catonsville, Md.</i>			



8552

08555  
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 70

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Carroll</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
X TOWN <u>Taneytown</u>		<u>Life</u>		TOWN <u>Rural Taneytown</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Faesen Road</u>				STREET ADDRESS (If rural, give location) <u>1</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
ROSE MATILDA MARY KLEIN				Sept 20 1955			
5. SEX: Female		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married		8. DATE OF BIRTH: April 14, 1908	
				9. AGE last birthday: 47 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>housework</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Own home</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Joseph Lang</u>				14. MOTHER'S MAIDEN NAME: <u>Lidwina Gutmann</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY No.: <u>none</u>		17. INFORMANT & ADDRESS: <u>Joseph A. Klein, 6130 Marglenn Ave., Balto., Md.</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
816X Immediate cause (a) <u>Intracranial Hemorrhage</u>							
DUE TO Antecedent cause(s) (b) <u>Acc. Skull.</u>							
Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>Faesen Road</u>		21c. (City or town) (County) (State) <u>Taneytown Carroll Md</u>		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>9 20 55 11 P.M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Automobile accident</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>James J. Marsh</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>9/20/55</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>Sept. 23, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>St. Joseph's Cemetery</u>		LOCATION (City, town, or county) (State) <u>Taneytown, Maryland</u>	
DATE REC'D BY LOCAL REG. <u>Sept 21, 1955</u>		REGISTRAR'S SIGNATURE <u>Ethel M. McHarg</u>		24. FUNERAL DIRECTOR <u>C.O. Fuss &amp; Son, Taneytown, Maryland</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

65731

UNITED STATES DEPARTMENT OF HEALTH, EDUCATION AND WELFARE  
NATIONAL EXAMINING BOARD FOR THE PROFESSION OF NURSING

Form No. 1 (Rev. 1-65)

Application for Membership

in the National Association of Registered Nurses

and the American Nurses Association

and the American Nurses Association

and the American Nurses Association

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BUREAU V. 2

SEP 23 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8553  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 74

08556  
Reg. Dist.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>City</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
X TOWN <u>Sykesville</u>		<u>7mo. 14days</u>		TOWN <u>Baltimore</u> <u>3 Vol-4</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>				STREET ADDRESS (If rural, give location) <u>1807 N. Broadway</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>ELIZABETH LAUSTER</u>				<u>September 22 1955</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>		8. DATE OF BIRTH: <u>6-18-76</u>	
9. AGE last birthday: <u>79</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Dressmaker</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>George Kurz</u>				14. MOTHER'S MAIDEN NAME: <u>Margaret Wack</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>Unk.</u>		17. INFORMANT & ADDRESS: <u>Hospital Records</u>			

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
Immediate cause (a) <u>Chronic mitral valvular disease</u>		DUE TO		<u>unknown</u>	
Antecedent cause(s) (b) <u>Carcinoma of the breast</u>		DUE TO		<u>months.</u>	
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>CBS assoc. with circulatory disturbance, with cerebral arteriosclerosis, with psychotic react.</u> Years					
19a. DATE OF OPERATION: <u>2</u>		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, street, office bldg., etc., INJURY <u>Hospital</u>		21c. (City or town) (County) (State) <u>Sykesville Carroll Maryland</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>9-3-55 2:10AM.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Patient fell striking rt. hip on bed</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <u>James J. Mahan</u>		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>9/22/55</u>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>9-27-55</u>		NAME OF CEMETERY OR CREMATORY <u>Bowdon Park</u>	
LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>		24. FUNERAL DIRECTOR <u>Arthur H. Knight-Hyland, Md.</u>		ADDRESS	
DATE REC'D BY LOCAL REG. <u>Sept. 26, 1955</u>		REGISTRAR'S SIGNATURE <u>C. Harry Ewer</u>			

BUREAU V. 8

SEP 30 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08557

8554

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Carroll</i>		MARYLAND		STATE <i>Md</i>		COUNTY <i>Carroll</i>	
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) <i>Sykesville</i>		LENGTH OF STAY (in this place) <i>Two 3 days</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Baltimore 14 03 X-2</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Springfield State Hospital</i>				STREET ADDRESS (If rural give location) <i>9209 Ridge Ave</i>			
3. NAME OF DECEASED: (First) <i>Evelyn</i> (Middle) <i>Lee</i> (Last) <i>Lucas</i>				4. DATE (Month) (Day) (Year) OF DEATH: <i>9 18 1955</i>			
5. SEX: <i>F</i>	6. COLOR OR RACE: <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>married</i>	8. DATE OF BIRTH: <i>12/17/1880</i>	9. AGE last birthday <i>74</i> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>home</i>		11. BIRTHPLACE (State or foreign country): <i>Ohio</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME: <i>Roland Lee</i>				14. MOTHER'S MAIDEN NAME: <i>Susanna ?</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>no</i> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>unk -</i>		17. INFORMANT & ADDRESS: <i>Hospital records</i>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
331X IMMEDIATE CAUSE						<i>hours</i>	
(A) <i>Cerebral Vascular accident</i>							
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.						<i>years</i>	
(B) <i>Cerebral arteriosclerosis</i>							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>C.B.S. on LFT disturbance of metabolism, growth or nutrition, LFT acute brain disease</i>						<i>years</i>	
19A. DATE OF OPERATION: <i>0</i>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>1/15</i> , 1955, to <i>9/18</i> , 1955, that I last saw the deceased alive on <i>9/18</i> , 1955, and that death occurred at <i>8:30</i> P.M. from the causes and on the date stated above.							
SIGNATURE <i>Gertrude M. Gross</i>		M.D. <i>Sykesville, Md.</i>		DATE SIGNED <i>9/18/55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>9-21-55</i>		NAME OF CEMETERY OR CREMATORY <i>Woodlawn</i>		LOCATION (City, town, or county) (State) <i>Woodlawn, Md.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>Sept. 19, 1955</i>		REGISTRAR'S SIGNATURE <i>C. Harry Allen</i>		24. FUNERAL DIRECTOR <i>Wm. Cook, Jr.</i>		ADDRESS <i>1217 Atlantic St. Balt. Md.</i>	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

1. Name of deceased: \_\_\_\_\_

2. Sex: \_\_\_\_\_

3. Age: \_\_\_\_\_

4. Date of birth: \_\_\_\_\_

5. Place of birth: \_\_\_\_\_

6. Date of death: \_\_\_\_\_

7. Cause of death: \_\_\_\_\_

8. Place of death: \_\_\_\_\_

9. Signature of physician: \_\_\_\_\_

10. Signature of registrar: \_\_\_\_\_

11. Signature of informant: \_\_\_\_\_

12. Signature of funeral director: \_\_\_\_\_

13. Signature of undertaker: \_\_\_\_\_

14. Signature of coroner: \_\_\_\_\_

15. Signature of health officer: \_\_\_\_\_

16. Signature of registrar: \_\_\_\_\_

17. Signature of informant: \_\_\_\_\_

18. Signature of funeral director: \_\_\_\_\_

19. Signature of undertaker: \_\_\_\_\_

20. Signature of coroner: \_\_\_\_\_

21. Signature of health officer: \_\_\_\_\_

22. Signature of registrar: \_\_\_\_\_

23. Signature of informant: \_\_\_\_\_

24. Signature of funeral director: \_\_\_\_\_

25. Signature of undertaker: \_\_\_\_\_

26. Signature of coroner: \_\_\_\_\_

27. Signature of health officer: \_\_\_\_\_

28. Signature of registrar: \_\_\_\_\_

29. Signature of informant: \_\_\_\_\_

30. Signature of funeral director: \_\_\_\_\_

31. Signature of undertaker: \_\_\_\_\_

32. Signature of coroner: \_\_\_\_\_

33. Signature of health officer: \_\_\_\_\_

34. Signature of registrar: \_\_\_\_\_

35. Signature of informant: \_\_\_\_\_

36. Signature of funeral director: \_\_\_\_\_

37. Signature of undertaker: \_\_\_\_\_

38. Signature of coroner: \_\_\_\_\_

39. Signature of health officer: \_\_\_\_\_

40. Signature of registrar: \_\_\_\_\_

41. Signature of informant: \_\_\_\_\_

BUREAU V. S.

SEP 22 1955

RECEIVED

8555

08558  
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 26

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY	Carroll	MARYLAND	STATE	Ohio	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town)		
X TOWN Patapsco			TOWN Cleveland 72X-3		
HOSPITAL OR INSTITUTION OR STREET ADDRESS			STREET ADDRESS (If rural, give location)		
Tank Road			12620 E. St. Claira		
3. NAME OF DECEASED:	(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month) (Day) (Year)
(Type or Print)	PATRICK	RAY	MC CLANAHAN	9/18/55	19
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR IF UNDER 24 HRS.
Male	White		Jan. 9. 1910	45 yrs.	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
press operator		Fisher Body Co.		Mass. Charleston W. Va.	
13. FATHER'S NAME:			14. MOTHER'S MAIDEN NAME:		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:	
		?		Mrs Anna M. McClanahan, 72X-3	

18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			
983X Immediate cause (a) Subdural and subarachnoid hemorrhage			
Antecedent cause(s) (b) Aspiration of blood			
Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c) Skull fracture			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)	
	Street	Patapsco Carroll Maryland	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work Not while at work	21f. HOW DID INJURY OCCUR?	
9/18/55 1:00 P.M.	work	Struck over head with piece of wood	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE		CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER M. D. ASSISTANT MEDICAL EXAM.	
William Updegraff		DATE SIGNED 9/19/55	
23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
	Sept 21. 55	Huntington W. Va.	Huntington W. Va.
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
9-20-55	Harriet Miller	J. E. Rogers	11 Westman

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 22 1955

BUREAU V. S.

8556

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>City</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
X TOWN <u>Sykesville</u>		<u>5mo. 28days</u>		TOWN <u>Baltimore (24)</u> <u>3V01-4</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>15</u> <u>Springfield State Hospital</u>				<u>924 S. Robinson Street</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH: <u>September 22 1955</u>			
<u>JOSEPH A. MEWSHAW</u>							
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
<u>Male</u>	<u>White</u>	<u>Widowed</u>	<u>10-15-73</u>	<u>81</u> yrs.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Watchman</u>			10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
					<u>Maryland</u>		
13. FATHER'S NAME: <u>Joseph Mewshaw</u>				14. MOTHER'S MAIDEN NAME: <u>Annie Martin Mewshaw</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Hospital Records</u>	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>420.1</u> IMMEDIATE CAUSE				<u>days</u>			
(A) <u>Myocardial Infarction</u> DUE TO							
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.				<u>days</u>			
(B) <u>Coronary artery occlusion</u> DUE TO							
(C) <u>Generalized arteriosclerosis &amp; hypertension</u>				<u>years</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>CBS assoc. with disturbance of metabolism, growth or nutrition, with senile brain disease, Yrs.</u>							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION <u>with psychotic reaction.</u>					
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9-14</u> , 1955, to <u>9-22</u> , 1955, that I last saw the deceased alive on <u>9-22</u> , 1955, and that death occurred at <u>7:40AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Walter H. Springfield</u>		ADDRESS <u>M. D. Springfield State Hosp.</u>		DATE SIGNED <u>9/22/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>SEPT 26/55</u>		NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL CEM.</u>		LOCATION (City, town, or county) (State) <u>4306 Frederick Rd-Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>September 24 1955</u>		REGISTRAR'S SIGNATURE <u>R.W.</u>		24. FUNERAL DIRECTOR <u>Marie Tialkowsky</u>		ADDRESS <u>1000 S. Kenwood Ave</u>	

MARGIN RESERVED FOR BINDING

BRITISH STATE DEPARTMENT OF HEALTH  
GENERAL HEALTH REPORT  
1918

THE following table shows the number of cases of the various diseases reported to the Registrar-General during the year 1918, and the number of deaths from each disease.

Disease	Cases	Deaths
Smallpox	1,234	56
Dysentery	5,678	123
Scarlet fever	3,456	89
Measles	12,345	34
Whooping cough	8,901	21
Diphtheria	2,345	67
Polio	1,567	45
Typhoid	4,567	101
Scarlet fever	3,456	89
Measles	12,345	34
Whooping cough	8,901	21
Diphtheria	2,345	67
Polio	1,567	45
Typhoid	4,567	101

The following table shows the number of cases of the various diseases reported to the Registrar-General during the year 1918, and the number of deaths from each disease.

Disease	Cases	Deaths
Smallpox	1,234	56
Dysentery	5,678	123
Scarlet fever	3,456	89
Measles	12,345	34
Whooping cough	8,901	21
Diphtheria	2,345	67
Polio	1,567	45
Typhoid	4,567	101

THE following table shows the number of cases of the various diseases reported to the Registrar-General during the year 1918, and the number of deaths from each disease.

Disease	Cases	Deaths
Smallpox	1,234	56
Dysentery	5,678	123
Scarlet fever	3,456	89
Measles	12,345	34
Whooping cough	8,901	21
Diphtheria	2,345	67
Polio	1,567	45
Typhoid	4,567	101

8557

08560

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 76

## 1. PLACE OF DEATH:

COUNTY Carroll

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)

TOWN Rural, Nr. Westminster

LENGTH OF STAY (in this place)

Life

HOSPITAL OR INSTITUTION OR STREET ADDRESS

Westminster, Md. R.D.1

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Carroll

CITY (If outside corporate limits write RURAL and give nearest town)

TOWN Rural, Nr. Westminster

STREET ADDRESS

(If rural, give location)

Westminster, Md. R.D.1

## 3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

MARYEVAMYERS

## 4. DATE OF DEATH

(Month)

(Day)

(Year)

Sept. 141955

## 5. SEX:

Female

## 6. COLOR OR RACE:

White

## 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

Widowed

## 8. DATE OF BIRTH:

6/5/1873

## 9. AGE last birthday:

82 yrs.

## IF UNDER 1 YEAR

## IF UNDER 24 HRS.

Months Days

Hours Min.

## 10a. USUAL OCCUPATION (Give kind of work done during most of work life, and if retired)

Housewife, Housework

## 10b. KIND OF BUSINESS OR INDUSTRY:

Her own home

## 11. BIRTHPLACE (State or foreign country):

Carroll Co., Md.

## 12. CITIZEN OF WHAT COUNTRY?

U.S.A.

## 13. FATHER'S NAME:

Joshua Engleman

## 14. MOTHER'S MAIDEN NAME:

Sarah Nickey

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

No.

## 16. SOCIAL SECURITY No.:

217-12-1320A

## 17. INFORMANT &amp; ADDRESS:

Mrs. Elmer Messinger, Alesia, Millers; Md.Mrs. Elmer Messinger

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause

(a)

DUE TO

Antecedent cause(s)

Diseases or conditions, if any,

giving rise to the above cause

stating underlying cause last

(b)

DUE TO

(c)

## II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDING OF OPERATION:

INTERVAL BETWEEN ONSET AND DEATH

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

## 21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

## 21c. (City or town)

(County)

(State)

## 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

## 21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

James J. ThomasCHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAM. ☒

DATE SIGNED

M. D.

9/14/55

## 23. BURIAL, CREMATION, REMOVAL (Specify):

Burial

## DATE THEREOF

9/17/55

## NAME OF CEMETERY OR CREMATORY

Methodist Cemetery

## LOCATION (City, town, or county)

Union Mills, Carroll Co., Md.

(State)

## DATE REC'D BY LOCAL REG.

9-10-55

## REGISTRAR'S SIGNATURE

Harriet Muller

## 24. FUNERAL DIRECTOR

J. M. Little

## ADDRESS

Littlestown, Pa.Rev. R. A. Little

Partner

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 19 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8558

## CERTIFICATE OF DEATH

08561  
Reg. Dist. No. 75

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Canoll</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Fredrick</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Marbleton</u>		LENGTH OF STAY (in this place) <u>2 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Walkersville</u>		COUNTY <u>Ladiesburg</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Lynwood Nursing Home</u>				STREET ADDRESS (If rural give location) <u>10X-2</u>			
3. NAME OF DECEASED: (First) <u>Eula</u> (Middle) <u>ESTELLE</u> (Last) <u>Norris</u>				4. DATE OF DEATH: (Month) <u>September</u> (Day) <u>23</u> (Year) <u>1955</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>		8. DATE OF BIRTH: <u>Dec 5, 1871</u>	
9. AGE last birthday: <u>83</u> yrs.		10. MONTHS <u>23</u> DAYS <u>19</u> HRS. <u>55</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>unknown</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>unknown</u>			
13. FATHER'S NAME: <u>William Norris</u>				14. MOTHER'S MAIDEN NAME: <u>Anna Kreglo</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>NO</u>				17. INFORMANT & ADDRESS: <u>Mrs. Shelma Frock, Walkersville Md</u>			
16. SOCIAL SECURITY No.: <u>—</u>							
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
<u>422.1</u> Immediate cause (a) <u>Chronic Myocarditis</u> Antecedent causes (s) (b) <u>Arteriosclerotic Cardio-Vascular disease</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) <u>—</u>						<u>—</u> <u>—</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>—</u>							
19a. DATE OF OPERATION: <u>—</u>				19b. MAJOR FINDINGS OF OPERATION: <u>—</u>			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT (Specify) <u>—</u>		PLACE (Home, farm, factory, street, office bldg., etc.) <u>—</u>		(CITY OR TOWN) <u>—</u>		(COUNTY) <u>—</u> (STATE) <u>—</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>—</u>		INJURY OCCURRED While at Work <input checked="" type="checkbox"/> Not While at Work <input type="checkbox"/>		HOW DID INJURY OCCUR? <u>—</u>			
22. I hereby certify that I attended the deceased from <u>June 23, 1953</u> , to <u>Sept 23, 1955</u> , that I last saw the deceased alive on <u>Sept 20, 1955</u> , and that death occurred at <u>7 A.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Joseph E. Bush M.D.</u>				ADDRESS <u>Hampstead Md</u>		DATE SIGNED <u>Sept 33, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Sept 25 1955</u>		NAME OF CEMETERY OR CREMATOR <u>Fairmount</u>		LOCATION (City, town, & county) (State) <u>Libertytown Md.</u>	
DATE RECD BY LOCAL REGISTRAR <u>Sept 25/55</u>		REGISTRAR'S SIGNATURE <u>Mrs. U.P. Danner</u>		24. FUNERAL DIRECTOR <u>J.C. Barton</u>		ADDRESS <u>Walkersville, Md.</u>	

10520

8737

BUREAU V. R.

SEP 30 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8559

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08562

## CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>Carroll</b>	MARYLAND	STATE <b>Maryland</b>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) <b>X</b> TOWN <b>Sykesville</b>	LENGTH OF STAY (in this place) <i>since 3-27-51</i>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Baltimore</b>	<b>3701-4</b>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>15 Springfield State Hospital</b>		STREET ADDRESS (If rural give location) <b>3125 Mareco Avenue</b>	
3. NAME OF DECEASED: (Type or Print) <b>Margareth Sidona O, MALLEY</b>		4. DATE (Month) (Day) (Year) OF DEATH: <b>Sept. 9, 1955</b>	
5. SEX: <b>female</b>	6. COLOR OR RACE: <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>married</b>	8. DATE OF BIRTH: <b>4-9-1904</b>
9. AGE last birthday <b>51</b> yrs.		IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY: <b>Home</b>	
11. BIRTHPLACE (State or foreign country): <b>Baltimore Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME: <b>John Petersen</b>		14. MOTHER'S MAIDEN NAME: <b>Philomena Nuth</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>no</b>		16. SOCIAL SECURITY NO. <b>21-24-</b>	
17. INFORMANT'S ADDRESS: <b>Records of Springfield State Hospital</b>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE <b>420.1</b>			
ANTECEDENT CAUSE (S):			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(A) <b>Coronary occlusion</b>		<b>few minutes</b>	
(B) <b>Hypertensive cardiovascular disease</b>		<b>about 5 years</b>	
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>Melancholia</b>			
<b>5 years</b>			
19A. DATE OF OPERATION: <b>0</b>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <b>March 27, 1951</b> , to <b>Sept. 9, 1955</b> , that I last saw the deceased alive on <b>Sept. 9, 1955</b> , and that death occurred at <b>7:05 PM</b> from the causes and on the date stated above.			
SIGNATURE <b>Florian Nadolski</b>		DATE SIGNED <b>Sept. 9, 1955</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>Sept. 13, 1955</b>	
NAME OF CEMETERY OR CREMATORY <b>Moreland Mem. Park</b>		LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
DATE REC'D BY LOCAL REGISTRAR <b>Sept. 10, 1955</b>		24. FUNERAL DIRECTOR ADDRESS <b>Leonard J. Ruck, 5305 Harford Road #14</b>	

BUREAU V. S.

SEP 13 1953

RECEIVED

08563

## MARYLAND STATE DEPARTMENT OF HEALTH

8560

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. *80*

1. PLACE OF DEATH COUNTY <i>Carroll</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Maryland</i> COUNTY <i>Carroll</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>New Windsor</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>New Windsor</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Main St.</i>		STREET ADDRESS (If rural, give location) <i>Main St.</i>	
3. NAME OF DECEASED (Type or Print) <i>HOWARD</i> (First) <i>E</i> (Middle) <i>PARIS</i> (Last)		4. DATE OF DEATH <i>Sept 22</i> 19 <i>53</i>	
5. SEX <i>Mr.</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Oct-1873</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>General Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Owner</i>	9. AGE last birthday <i>81</i> yrs. If under 1 year Months Days If under 24 hrs Hours Min.
11. BIRTHPLACE (State or foreign country) <i>Shoreland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>George Paris</i>		14. MOTHER'S MAIDEN NAME <i>Ida Paris</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY No. <i>None</i>	
17. INFORMANT AND ADDRESS <i>May S. Paris, New Windsor, Md</i>			

## 18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH <i>None</i>
4201 Immediate cause (a) <i>Myocardial Infarction</i>		
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<i>Burial</i>	<i>9/25/53</i>	<i>James C. New</i>	<i>Cockeysville, Md</i>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<i>Sept 27/53</i>	<i>Ernest Bender</i>	<i>R. W. Hartzler &amp; Sons</i>	<i>New Windsor, Md</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

0072

RECEIVED

W. J. B. C. W.

BUREAU V. R.

SEP 28 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

08564

CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

Reg. Dist. No. *80*

8561

1. PLACE OF DEATH COUNTY <i>Carroll</i>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Maryland</i> COUNTY <i>Carroll</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>New Windsor</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>New Windsor</i>	
TOWN <i>New Windsor</i>		TOWN <i>New Windsor</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Church St</i>		STREET ADDRESS (If rural, give location) <i>Church St</i>	
3. NAME OF DECEASED (Type or Print)	(First) <i>MARIE</i>	(Middle) <i>CARRIE</i>	(Last) <i>PETRY</i>
4. DATE OF DEATH	(Month) <i>Sept</i>	(Day) <i>1</i>	(Year) <i>1955</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>W</i>	8. DATE OF BIRTH <i>4/3/1899</i>
9. AGE last birthday <i>55</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Nathan H. Haines</i>		14. MOTHER'S MAIDEN NAME <i>Maggie Carr</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY No. <i>15-14-2712</i>	
17. INFORMANT <i>W. Harold Petry, New Windsor, Md.</i>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

974X Immediate cause

(a)

*Suffocation*

Antecedent cause(s)

Disease or condition, if any, giving rise to the above cause, stating the underlying cause last

(b)

*Strangling by the neck*

(c)

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing in the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, OF office, etc.)  
INJURY *Home*

(CITY OR TOWN)

(COUNTY)

*New Windsor Carroll*

TIME (Month) (Day) (Year) (Hour) OF INJURY *9 1 55 7A* m.

INJURY OCCURRED While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR?

*Strangling*

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☐ suicide ☒ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

*James J. March Deputy Medical Examiner - Westminster Md 9/1/55*

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

*Sept 12/55*

*Ernest Benedek*

*D. D. Hartzler & Sons*

*New Windsor, Md.*

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 6 1955

BUREAU V. I.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08565

8562

## CERTIFICATE OF DEATH

Reg. Dist. No. 70

1. PLACE OF DEATH- COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> TOWN <u>Rt. 1, Taneytown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Route #1, Taneytown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>		STREET ADDRESS (If rural, give location) <u>7</u>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <u>Ida</u> (Middle) <u>Rebecca</u> (Last) <u>Phillips</u>		(Month) <u>Sept.</u> (Day) <u>11.</u> (Year) <u>19 55</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Jan. 1, 1865</u>
9. AGE last birthday <u>90</u> yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Nusbaum</u>		14. MOTHER'S MAIDEN NAME <u>Lydia Hesson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Luther Zimmerman, Taneytown, Maryland</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## INTERVAL BETWEEN ONSET AND DEATH

199.1 Immediate cause <u>Cerebro-Vascular Accident</u>	Interval <u>16 days</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	
(a) <u>Jaundice Obstructive due to Abdominal malignancy</u>	<u>23 days</u>
(c) <u>Hypertension Arteriosclerotic</u>	<u>—</u>

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION <u>None</u>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 19, 1955, to Sept. 11, 1955, that I last saw the deceased alive on Sept. 4, 1955, and that death occurred at 3:10 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

E. Ambler ThompsonM.D.Taneytown, Md.9-12-55

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>Sept. 14, 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Baust Cemetery</u>	LOCATION (City, town, or county) (State) <u>Tyrone, Carroll Co. Maryland</u>
DATE REC'D BY LOCAL REG. <u>Sept 12, 1955</u>	REGISTRAR'S SIGNATURE <u>Ethel M. Mahring</u>	24. FUNERAL DIRECTOR <u>C.O. Fuss &amp; Son, Taneytown, Maryland</u>	

local

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 19 1955

BUREAU V. R.

MARYLAND

08566  
STATE DEPARTMENT OF HEALTH

8563

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>CARROLL</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>SYKESVILLE</u>				CITY (If outside corporate limits, write RURAL and give nearest town) <u>SYKESVILLE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>MINERAL HILL RD</u>				STREET ADDRESS (If rural, give location) <u>MINERAL HILL RD</u>			
3. NAME OF DECEASED (Type or Print)		(First) <u>LILLIAN</u>		(Middle) <u>GRAY</u>		(Last) <u>RICHARDSON</u>	
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>SINGLE</u>		8. DATE OF BIRTH <u>DEC. 26-1871</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPING</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		9. AGE last birthday <u>83</u> yrs.		4. DATE OF DEATH <u>SEPT 9</u> 19 <u>55</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>JOHN R. RICHARDSON</u>				14. MOTHER'S MAIDEN NAME <u>FRANCES J. GRAY</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT AND ADDRESS <u>Mrs. CHARA RICHARDSON - SYKESVILLE</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
443X Immediate cause (a) <u>CONGESTIVE HEART FAILURE (ACUTE) E</u>						2 DAYS	
Antecedent cause(s) (b) <u>PULMONARY EDEMA,</u>							
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>HYPERTENSIVE - C.V. DISEASE - E</u>						10 YEARS	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>HEART BLOCK -</u>							
19a. DATE OF OPERATION <u>0</u>				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office hldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>APRIL</u> , 19 <u>53</u> , to <u>SEPT 9</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>SEPT 9</u> , 19 <u>55</u> , and that death occurred at <u>5:30 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Thomas E. Hauler</u>		(Degree or title) <u>MD</u>		ADDRESS <u>Randallstown, Md</u>		DATE SIGNED <u>9-9-55</u>	
23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		DATE <u>9-12-55</u>		NAME OF CEMETERY OR CREMATORY <u>Springfield</u>		LOCATION (City, town, or county) (State) <u>Chicksville, Md</u>	
DATE REC'D BY LOCAL REG <u>Sept. 10, 1955</u>		REGISTRAR'S SIGNATURE <u>C. Harry Thur</u>		24. FUNERAL DIRECTOR <u>Walter A. Wright - Sykesville, Md</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

BUREAU V. S.

SEP 13 1955

RECEIVED

1955  
SEP 13

1955  
SEP 13

8564

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08567

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Carroll</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>---</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>X</u> TOWN <u>Rural - Sykesville</u>	LENGTH OF STAY (in this place) <u>since 9/21/55</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore City</u> <u>3Y01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>		STREET ADDRESS (If rural give location) <u>1833 Hope Street</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Elmer</u> <u>Ellsworth</u> <u>ROBINSON, Jr.</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>September 6</u> <u>1955</u>	
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>single</u>	8. DATE OF BIRTH: <u>February 5, 1890</u>
9. AGE last birthday: <u>65</u> yrs.		IF UNDER 1 YEAR: Months <u>---</u> Days <u>---</u> Hours <u>---</u> Min. <u>---</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Painter's helper</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>---</u>	11. BIRTHPLACE (State or foreign country): <u>Baltimore, Maryland</u>
13. FATHER'S NAME: <u>Elmer E. Robinson, Sr.</u>		14. MOTHER'S MAIDEN NAME: <u>Ida Evans</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service) <u>---</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT & ADDRESS: <u>Records of Springfield State Hospital</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Interstitial pneumonia</u>		<u>2-3 days</u>	
ANTECEDENT CAUSE (S) (B) <u>Acute pericarditis due to unknown bacteria</u>		<u>about 2 weeks</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>---</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Cancer of the larynx</u>		<u>months?</u>	
<u>Schizophrenia, paranoid type</u>		<u>more than 10 yrs.</u>	
19A. DATE OF OPERATION: <u>---</u>	19B. MAJOR FINDINGS OF OPERATION: <u>---</u>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) INJURY OCCUR?	(County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>---</u> M.	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? <u>---</u>	
22. I hereby certify that I attended the deceased from <u>Feb., 28, 1950</u> , to <u>Sept. 5, 1955</u> that I last saw the deceased alive on <u>Sept. 5, 1955</u> , and that death occurred at <u>6:15 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Martin Gross, M.D.</u>		DATE SIGNED <u>9/6/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>9-9-55</u>	NAME OF CEMETERY OR CREMATORY <u>Landon Park</u>
LOCATION (City, town, or county) (State) <u>Sykesville, Maryland</u>		24. FUNERAL DIRECTOR ADDRESS <u>George J. Guthrie 1735 Hanford Ave</u>	
DATE REC'D BY LOCAL REGISTRAR <u>9/9/55</u>		REGISTRAR'S SIGNATURE <u>W.W. Hedrick</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

REPORT OF THE GEOLOGICAL SURVEY

OF THE GEOLOGICAL SURVEY OF THE TERRITORY OF ARIZONA

IN RESPONSE TO A RESOLUTION OF THE HOUSE OF REPRESENTATIVES

PASSED MAY 12, 1890

AND A RESOLUTION OF THE SENATE

PASSED MAY 12, 1890

AND A RESOLUTION OF THE HOUSE OF REPRESENTATIVES

PASSED MAY 12, 1890

AND A RESOLUTION OF THE SENATE

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AND A RESOLUTION OF THE SENATE

PASSED MAY 12, 1890

AND A RESOLUTION OF THE HOUSE OF REPRESENTATIVES

8565

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Carroll</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>TOWN Sykesville</u>	LENGTH OF STAY (in this place) <u>23 days.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWN Chevy Chase</u>	<u>15X-2</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital.</u>		STREET ADDRESS (If rural give location) <u>7505 Lynn Drive</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Nellie</u> <u>Robinson</u>		4. DATE OF DEATH: (Month) (Day) (Year) <u>Sept. 18 19 55</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widowed</u>	8. DATE OF BIRTH: <u>2-28-76</u>
9. AGE last birthday: <u>79</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Indiana</u>	
11. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>William Elliot</u>		14. MOTHER'S MAIDEN NAME: <u>Nancy Andamile</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>unk</u>	
17. INFORMANT & ADDRESS: <u>Mr. Myles Robinson (son)</u> <u>7505 Lynn Drive, Chevy Chase, Md.</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			Interval Between Onset And Death
Immediate cause (a) <u>Myocardial infarction.</u>			<u>days.</u>
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>Coronary artery thrombosis</u>			<u>days.</u>
(c) <u>Generalized arteriosclerosis and Hypertension</u>			<u>years</u>
11. OTHER SIGNIFICANT CONDITIONS <u>Chronic Brain syndrome, with cerebral arteriosclerosis and psychotic reactions—Bronchopneumonia</u>			
19a. DATE OF OPERATION: <u>0</u>			
19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY) (STATE)
<u>SUICIDE</u>	<u>INJURY</u>		
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>8-26-1955</u> , to <u>9-18-1955</u> , that I last saw the deceased alive on <u>9-18-1955</u> , and that death occurred at <u>3:50 p.m.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Edmund Lustman</u>		DATE SIGNED <u>9-18-55</u>	
ADDRESS <u>Springfield State Hospital.</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>9-21-55</u>	<u>Green lawn</u>	<u>Columbus, Ohio</u>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>Sept. 19, 1955</u>	<u>C. Henry Eiken</u>	<u>Robert A. Pennington</u>	<u>Bethesda, Md.</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 22 1955

BUREAU V. S.

8565

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

## I. PLACE OF DEATH:

COUNTY Balto. Carroll MARYLAND  
 CITY (If outside corporate limits, write RURAL and give nearest town)  
 OR TOWN Eldersburg, Md. LENGTH OF STAY (in this place)  
 HOSPITAL OR INSTITUTION OR STREET ADDRESS Grandview Mansion  
Route No. 32

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY A. A.  
 CITY (If outside corporate limits, write RURAL and give nearest town)  
 OR TOWN Glen Burnie  
 STREET ADDRESS 12 Georgia Ave., N. W. (If rural give location)

## 3. NAME OF DECEASED:

(First) PAULINE (Middle) W. (Last) RUMMEL

4. DATE OF DEATH: (Month) Sept. (Day) 17, (Year) 19 55

## 5. SEX:

F

## 5. COLOR OR RACE:

W

## 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

widowed

## 8. DATE OF BIRTH:

Oct. 2, 1876

## 9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.

78 yrs.

Months

Days

Hours

Min.

## 10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired):

Housewife

## 10b. KIND OF BUSINESS OR INDUSTRY:

at home

## 11. BIRTHPLACE (State or foreign country):

Germany

## 12. CITIZEN OF WHAT COUNTRY?

U. S. A.

## 13. FATHER'S NAME:

? Krieger

## 14. MOTHER'S MAIDEN NAME:

Unknown

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

no

## 16. SOCIAL SECURITY No.:

none

## 17. INFORMANT &amp; ADDRESS:

Glen Burnie, Md.  
 Mr. Adolph Nethen - 12 Georgia Ave., N. W.

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0 Immediate cause

(a)

Hypertensive cardiovascular disease

DUE TO

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

arteriosclerotic heart disease

DUE TO

(c)

progressive senile changes

Interval Between Onset And Death

several years

several years

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY ?

Yes ☐ No ☒

## 21. ACCIDENT SUICIDE HOMICIDE (Specify)

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)  
 OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m.

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR ?

22. I hereby certify that I attended the deceased from July, 1953, to 17 Sept., 1955, that I last saw the deceased

alive on 17 Sept., 1955, and that death occurred at 9:40 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

## 23. BURIAL, CREMATION, REMOVAL (Specify)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

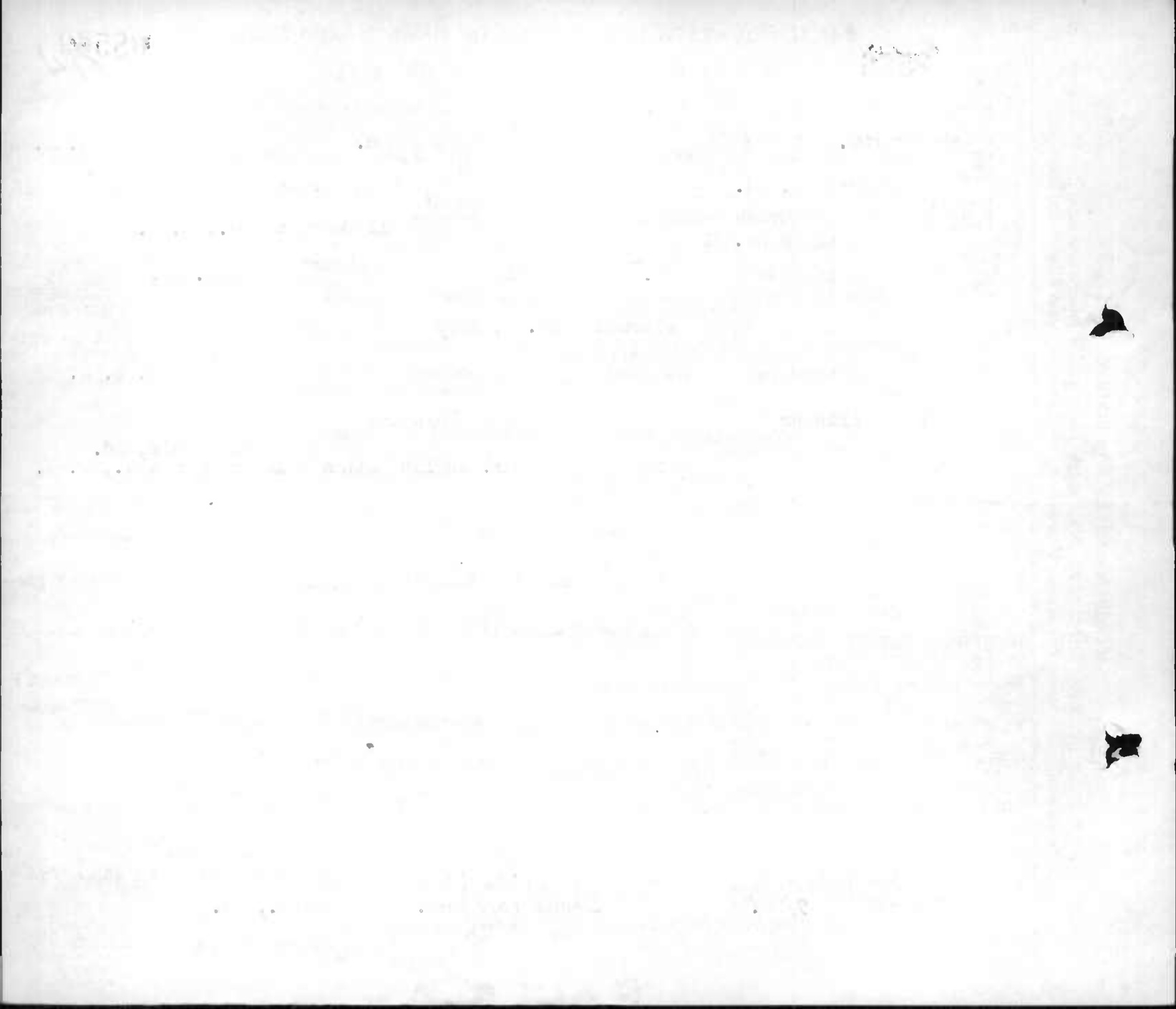
## (State)

## DATE REC'D BY LOCAL REGISTRAR

## REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

## ADDRESS



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8567

## CERTIFICATE OF DEATH

Reg. Dist. No. 08570 74

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>CARROLL</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>X Rural - Sykesville</b>		LENGTH OF STAY (in this place) <b>8 months</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>15 Springfield State Hospital</b>				STREET ADDRESS (If rural give location) <b>542 Radnor Avenue</b>			
3. NAME OF DECEASED: (First) (Middle) (Last) <b>BERTHA LOUISE RUSSELL</b>				4. DATE (Month) (Day) (Year) OF DEATH: <b>9 19 19 55</b>			
5. SEX: <b>F</b>	6. COLOR OR RACE: <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>single</b>	8. DATE OF BIRTH: <b>6/9/74</b>	9. AGE last birthday <b>81</b> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>teacher</b>		10B. KIND OF BUSINESS OR INDUSTRY: <b>education</b>		11. BIRTHPLACE (State or foreign country): <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME: <b>Marcus Russell</b>				14. MOTHER'S MAIDEN NAME: <b>Helen Spoor</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <b>9</b> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <b>Record, Springfield State Hospital</b>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <b>414X</b>							
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) <b>Bronchopneumonia</b>						3 days	
DUE TO							
(B) <b>Rheumatic valvulitis, inactive, with deformity of mitral valve</b>						years	
DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>Chronic Brain Syndrome associated with senile brain disease, with psychotic reaction</b>						1 year	
19A. DATE OF OPERATION: <b>2</b>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>9/16</b> , 19 <b>55</b> to <b>9/19</b> , 19 <b>55</b> that I last saw the deceased alive on <b>9/18</b> , 19 <b>55</b> , and that death occurred at <b>2:30 A.M.</b> from the causes and on the date stated above.							
SIGNATURE <b>Walter H. Sourenfeldt</b>		M. D.		ADDRESS <b>Sykesville, Maryland</b>		DATE SIGNED <b>9/19/55</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		DATE THEREOF <b>Sept 21, 1955</b>		NAME OF CEMETERY OR CREMATORY <b>Govans Presbyterian</b>		LOCATION (City, town, or county) (State) <b>Baltimore Md</b>	
DATE REC'D BY LOCAL REGISTRAR <b>20-55</b>		REGISTRAR'S SIGNATURE <b>H. J. Federal</b>		24. FUNERAL DIRECTOR <b>Glenn F. Seitz</b>		ADDRESS <b>5209 York Rd</b>	



CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Carroll</u>	MARYLAND	STATE <u>Md</u>	COUNTY <u>Balto</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Sykesville</u>	LENGTH OF STAY (in this place) <u>4 yrs</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore City</u> <u>03X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>		STREET ADDRESS (If rural give location) <u>2339 Woodridge Ave.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) <u>Lee</u> <u>Edward</u> <u>(ALSO KNOWN AS) Schmidt SMITH</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Spt.</u> <u>4</u> <u>1955</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>S</u>	8. DATE OF BIRTH: <u>6-20-1920</u>
9. AGE last birthday: <u>35</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>barber</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>-----</u>	
11. BIRTHPLACE (State or foreign country): <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Robert E. Smith</u>		14. MOTHER'S MAIDEN NAME: <u>Elizabeth Furlong</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service) <u>-----</u>		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT & ADDRESS: <u>Records of Springfield State Hospital</u>			
15. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>chron. mitral valvular heart disease</u>		<u>16 yrs</u>	
ANTECEDENT CAUSE (S) (B) <u>rheumatic fever</u>		<u>more than 15 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>chron. bronchitis due to asthma</u>		<u>? years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>pulmonary edema and bronchopneumonia</u>		<u>??</u>	
19A. DATE OF OPERATION: <u>2</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 28</u> , 1952, to <u>Spt. 4</u> , 1955, that I last saw the deceased alive on <u>Spt. 4</u> , 1955, and that death occurred at <u>11:50 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Martin Gross, M.D.</u>		DATE SIGNED <u>Spt. 5, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>9-7-55</u>	
NAME OF CEMETERY OR CREMATORY <u>BALTIMORE CEM. BALTIMORE MD.</u>		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REGISTRAR <u>9-6-55</u>		REGISTRAR'S SIGNATURE <u>G. H. Hedrick</u>	
24. FUNERAL DIRECTOR <u>W. Jenkins</u>		ADDRESS <u>4905 York Rd.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# UNITED STATES DEPARTMENT OF HEALTH

100

OFFICE OF THE ASSISTANT SECRETARY FOR PUBLIC HEALTH

WASHINGTON, D. C.

REPORT OF THE ASSISTANT SECRETARY FOR PUBLIC HEALTH ON THE PROGRESS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES IN THE FISCAL YEAR 1964

Submitted to the President and the Congress

by the Assistant Secretary for Public Health

and the Assistant Secretary for Health Policy and Statistics

for the year ending June 30, 1964

by the Assistant Secretary for Public Health

and the Assistant Secretary for Health Policy and Statistics

for the year ending June 30, 1964

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and the Assistant Secretary for Health Policy and Statistics

for the year ending June 30, 1964

by the Assistant Secretary for Public Health

and the Assistant Secretary for Health Policy and Statistics

08572

MARYLAND

STATE DEPARTMENT OF HEALTH

8569

## CERTIFICATE OF DEATH

Reg. Dist. No. 78

1. PLACE OF DEATH- COUNTY <b>Carroll</b>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>Maryland</b> COUNTY <b>Carroll</b>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) X TOWN <b>Rural, Nr. Taneytown</b>		CITY (If outside corporate limits, write RURAL and give nearest town) X TOWN <b>Rural, Nr. Taneytown</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Mailing Address Littlestown, Pa. R.D.1, Carroll</b>		STREET ADDRESS <b>Mailing Address Littlestown, Pa. R.D.1 Carroll Co.</b>	
3. NAME OF DECEASED (Type or Print)	(First) <b>Melvin</b>	(Middle) <b>H.</b>	(Last) <b>Sell</b>
4. DATE OF DEATH	(Month) <b>9/12/55</b>	(Day) <b>19</b>	(Year) <b>19</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>7/28/1897</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Merchant Grocery Store</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Grocery Store</b>	9. AGE last birthday <b>58</b> yrs.
11. BIRTHPLACE (State or foreign country) <b>Frederick Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jacob F. Sell</b>		14. MOTHER'S MAIDEN NAME <b>Emma Jane Michael</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Y no, or unknown) (If year, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY No. <b>212-03-0507</b>	
17. INFORMANT AND ADDRESS <b>Mrs Melvin Sell Littlestown, Pa.</b>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
578X Immediate cause (a) <b>Embolic Meningitis</b>		
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <b>Infection of meningitis - High Blood Pressure</b>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from <b>July 7, 1955</b> , to <b>Sept 12, 1955</b> , that I last saw the deceased alive on <b>July 12, 1955</b> , and that death occurred at <b>2:45 P. m.</b> , from the causes and on the date stated above.			
SIGNATURE <b>W. H. Legg</b>		DATE SIGNED <b>9-12-55</b>	
23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<b>Burial</b>	<b>9/15/55</b>	<b>Reformed Cemetery</b>	<b>Taneytown, Carroll Co., Md.</b>
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <b>Sept 12, 1955 Ethel M. Mehring</b>		24. FUNERAL DIRECTOR ADDRESS <b>J. M. Lott &amp; Son Littlestown, Pa.</b>	

MARGIN RESERVED FOR BINDING

RECEIVED

SEP 19 1955

BUREAU V. S.

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

8570

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Carroll</b>		MARYLAND		STATE <b>Md.</b>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>Henryton</b>		LENGTH OF STAY (in this place) <b>11 Days</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		<b>3V01-4</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Henryton, Maryland</b>				STREET ADDRESS (If rural give location) <b>1102 Edmondson Avenue</b>			
3. NAME OF DECEASED: (Type or Print) <b>Henry W. Sewell</b>				4. DATE OF DEATH: (Month) <b>9-</b> (Day) <b>27-</b> (Year) <b>1955</b>			
5. SEX: <b>Male</b>	6. COLOR OR RACE: <b>Negro</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>Married</b>	8. DATE OF BIRTH: <b>1-27-1891</b>	9. AGE last birthday: <b>64</b> yrs. If UNDER 1 YEAR: Months Days Hours Min.			
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <b>Frederick Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME: <b>William Sewell</b>				14. MOTHER'S MAIDEN NAME: <b>Willetta Fry</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <b>No</b>		16. SOCIAL SECURITY No.: (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS: <b>Henry W. Sewell - 1102 Edmondson Ave.</b>			

18. MEDICAL CERTIFICATION						Interval Between Onset And Death	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<b>002X</b> Immediate cause (a) <b>Far advanced bilateral pulmonary tuberculosis</b> DUE TO Antecedent causes (s) (b) <b>Cardiac insufficiency</b> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (c)							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: <b>0</b>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) <b>SUICIDE</b>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <b>INJURY</b>		(CITY OR TOWN) (COUNTY) (STATE)			
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>9-16-1955</b> , to <b>9-27-1955</b> , that I last saw the deceased alive on <b>9-27-1955</b> , and that death occurred at <b>10:40 A.M.</b> , from the causes and on the date stated above.							
SIGNATURE <b>T.F. [Signature]</b>		(Degree or title) <b>M.D.</b>		ADDRESS <b>Henryton, Maryland</b>		DATE SIGNED <b>9-27-55</b>	
23. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		DATE THEREOF <b>9-30-55</b>		NAME OF CEMETERY OR CREMATORY <b>Arbutus Memorial Cemetery</b>		LOCATION (City, town, or county) (State) <b>Baltimore 27, Maryland</b>	
DATE REC'D BY LOCAL REGISTRAR <b>9-27-55</b>		REGISTRAR'S SIGNATURE <b>[Signature]</b>		24. FUNERAL DIRECTOR <b>[Signature]</b>		ADDRESS <b>[Signature]</b>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

SEP 29 1955

RECEIVED

8571

## CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Carroll</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>Carroll</i>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Rural, Westminster</i>	LENGTH OF STAY (in this place) <i>70 yrs.</i>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Rural, Westminster, Md.</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>21 Charles St.</i>		STREET ADDRESS (If rural give location) <i>21 Charles St.</i>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <i>IRENE</i>	(Middle)	(Last) <i>SHEFFEY</i>	(Month) <i>Sept.</i> (Day) <i>16</i> (Year) <i>1955</i>
5. SEX: <i>F.</i>	6. COLOR OR RACE: <i>Colored</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>widowed</i>	8. DATE OF BIRTH: <i>June 28, 1885</i>
9. AGE last birthday: <i>70</i> yrs.		10. BIRTHPLACE (State or foreign country): <i>Westminster, Md.</i>	
11. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <i>domestic</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME: <i>Thomas Dixon</i>		14. MOTHER'S MAIDEN NAME: <i>Adeline Mason</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.: <i>Thomas A. Dixon, Westminster, Md.</i>	
17. INFORMANT & ADDRESS:		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death	
442X Immediate cause (a) <i>Cerebral hemorrhage</i>		8 da	
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <i>Cardio Renal disease &amp; Hypertension</i>		5-10 yrs	
(260X) (c) <i>diabetes mellitus</i>		5-6 yrs	
11. OTHER SIGNIFICANT CONDITIONS		20. AUTOPSY?	
Conditions contributing to the death but not related to the disease or condition causing death.		Yes <input type="checkbox"/> No <input type="checkbox"/>	
19a. DATE OF OPERATION: <i>195-1</i>		19b. MAJOR FINDINGS OF OPERATION (Specify): <i>amputated Rt Leg. Hip.</i>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		22. I hereby certify that I attended the deceased from <i>Sept 8, 1955</i> , to <i>Sept 16, 1955</i> , that I last saw the deceased alive on <i>Sept 14, 1955</i> , and that death occurred at <i>3:15 P.M.</i> , from the causes and on the date stated above.	
PLACE (Home, farm, factory, street, office bldg., etc.)		CITY OR TOWN	
INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
TIME (Month) (Day) (Year) (Hour) OF INJURY		DATE SIGNED	
SIGNATURE <i>Wylem Speichers</i>		ADDRESS <i>Westminster Md</i>	
23. BURIAL, CREMATION, REMOVAL (Specify)		24. FUNERAL DIRECTOR	
DATE THEREOF <i>Sept. 19, 55</i>		NAME OF CEMETERY OR CREMATORY <i>Elbow Creek Cemetery</i>	
LOCATION (City, town, or county) (State) <i>Rural, Westminster, Md.</i>		DATE REC'D BY LOCAL REGISTRAR <i>9-17-55</i>	
REGISTRAR'S SIGNATURE <i>H. A. Miller</i>		ADDRESS <i>J. S. Myers Jr., Westminster, Md.</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 19 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8572

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08575

Item 9, Film 187 10-7-55 et

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
X TOWN <u>Sykesville</u>		2 month 27 days		TOWN <u>Walkersville</u> 10X-2			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
15 <u>Springfield State Hospital</u>				✓			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
(Type or Print) <u>CHARLES WILLIAM SMITH</u>				<u>Sept. 27 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours
<u>Male</u>	<u>White</u>	<u>Widowed</u>	<u>2-24-82</u>	<u>73</u> yrs.	<u>11</u> yrs.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):			10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?
<u>Cattle Dealer</u>			<u>Unk -</u>		<u>Maryland</u>		<u>U.S.A.</u>
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>James W. Smith</u>				<u>Unk -</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<u>No</u>				<u>Unk -</u>		<u>Hospital records</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE							
(A) <u>Carcinoma of the stomach with metastasis into</u>							
ANTECEDENT CAUSE (S):							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(B) <u>pancreas and transverse colon</u>						months	
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						Unknown	
<u>CBS associated with senile brain disease with psychotic reaction.</u>							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
<u>9-22-55</u>		<u>Gastric - colic fistula, probably carcinomatous.</u>					
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6-30</u> , 19 <u>55</u> , to <u>9-27</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>9-27</u> , 19 <u>55</u> , and that death occurred at <u>1:25PM</u> , from the causes and on the date stated above.							
SIGNATURE				ADDRESS		DATE SIGNED	
<u>Walther H. Jounayfeldt</u>				<u>M. D. Springfield State Hosp.</u>		<u>10-27-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Cremation</u>		<u>Oct 3, 1955</u>		<u>Fort Lincoln Cemetery Washington</u>		<u>D.C.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Sept. 29, 1955</u>		<u>C. Henry (unclear)</u>		<u>MR. Etchison &amp; Son - Frederick, Md.</u>		<u>Md.</u>	

RECEIVED

OCT 5 1955

BUREAU V. 2

08576

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

8573

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH- COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> TOWN <u>Mt. Airy</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Mt. Airy</u> <u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) <u>CHARLES</u> (Middle) <u>W.</u> (Last) <u>SPENCER</u>		4. DATE OF DEATH (Month) <u>Sept</u> (Day) <u>13</u> (Year) <u>1955</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>4-22-1876</u>
9. AGE last birthday <u>79</u> yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Watchman retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bethlehem Steel</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>David Spencer</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Harris</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>219-05-2272</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Margaret Spencer, Same</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
241X Immediate cause (a) <u>Cardiac Failure</u>			<u>Sudden</u>
Antecedent cause(s) (b) <u>Severe Bronchial Asthma</u>			<u>yes</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
INJURY			
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>1930</u> , to <u>Sept 13, 1955</u> , that I last saw the deceased alive on <u>Sept 13, 1955</u> , and that death occurred at <u>3 P</u> m., from the causes and on the date stated above.			
SIGNATURE <u>C. M. Waltz</u>		ADDRESS <u>Winfield, Md</u>	
DATE SIGNED <u>9/13/55</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>9-16-1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Sams Creek Brethren</u>		LOCATION (City, town, or county) (State) <u>Carroll Co., Maryland</u>	
DATE REC'D BY LOCAL REG. <u>Sept. 16, 1955</u>		REGISTERAR'S SIGNATURE <u>Robert R. Hewitt</u>	
		24. FUNERAL DIRECTOR <u>C. M. Waltz, Winfield, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 19 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8574

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08577

## CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Carroll</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Montgomery</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) X TOWN <b>Rural - Sykesville</b>		LENGTH OF STAY (in this place) <b>38Y 8M 18 D</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Gaithersburg</b> <b>15X-2</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Springfield State Hospital</b>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last) <b>Mertie Estelle STARNER</b>				4. DATE (Month) (Day) (Year) OF DEATH: <b>98 8 1955</b>			
5. SEX: <b>Female</b>	6. COLOR OR RACE: <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>Single</b>	8. DATE OF BIRTH: <b>7/3/94</b>	9. AGE last birthday <b>61</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>none</b>		10B. KIND OF BUSINESS OR INDUSTRY: <b>none</b>		11. BIRTHPLACE (State or foreign country): <b>Montgomery Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME: <b>Charles C. Starnier</b>				14. MOTHER'S MAIDEN NAME: <b>Bertie Baldwin</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <b>Yunk -</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT & ADDRESS: <b>Record, Springfield State Hospital</b>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <b>572.2</b>						<b>36 hours</b>	
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.						<b>unknown</b>	
(A) <b>Septicemia</b>							
(B) <b>Ulcerative colitis</b>							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
<b>Schizophrenic reaction, hebephrenic circular type 40 yrs.</b>							
19A. DATE OF OPERATION: <b>2</b>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>9/6</b> , 1955, to <b>9/8</b> , 1955, that I last saw the deceased alive on <b>9/7</b> , 1955, and that death occurred at <b>2:50AM</b> (DST), from the causes and on the date stated above.							
SIGNATURE <b>Walter H. Spikesville</b>		ADDRESS <b>M. D. Spikesville, Maryland</b>		DATE SIGNED <b>9/8/55</b>		(State)	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>9-10-55</b>		NAME OF CEMETERY OR CREMATORY <b>Lorraine</b>		LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
DATE REC'D BY LOCAL REGISTRAR <b>Sept. 9, 1955</b>		REGISTRAR'S SIGNATURE <b>C. Harry Eiler</b>		24. FUNERAL DIRECTOR <b>Wm Cook Inc. 1217 St Paul St.</b>			

BUREAU V. S.

SEP 18 1965

RECEIVED

08578

## MARYLAND STATE DEPARTMENT OF HEALTH

8575

CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERSReg. Dist. No. 80

1. PLACE OF DEATH - COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>New Windsor</u> X	
TOWN <u>New Windsor</u>		TOWN <u>New Windsor</u> X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>New Windsor</u>		STREET ADDRESS (If rural, give location) <u>Rural</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>JESSE THOMAS STEVENSON</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Sept. 27 1955</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Aug. 1898</u> 77 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farmer</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Alfred Stevenson</u>		14. MOTHER'S MAIDEN NAME <u>Helen Sweigart</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Orpha Stevenson, New Windsor, Md</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.1  
Immediate cause(a) Arteriosclerotic C. V. disease

INTERVAL BETWEEN ONSET AND DEATH

2 years +

## Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☒21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

## SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

James J. Marsh Deputy Medical Examiner Westminster Md 9/27/55

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE THEREOF 9/29/55 NAME OF CEMETERY OR CREMATORY Knickerbocker C.W. LOCATION (City, town, or county) Westminster, Md (State)

DATE REC'D BY LOCAL REG. Sept 27 REGISTRAR'S SIGNATURE C. W. Spaworth 24. FUNERAL DIRECTOR D. N. Hartman & Sons ADDRESS New Windsor, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. A.

SEP 29 1955

RECEIVED

8576

08579

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** No. 74

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Sykesville</u> <u>Carroll</u>	MARYLAND	STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>X TOWNRural - Sykesville</u>	LENGTH OF STAY (in this place) <u>3 months</u>	CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Germantown</u>	<u>15X-2</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>		STREET ADDRESS (If rural, give location) ✓	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <u>Cora</u>	(Middle) <u>E</u>	(Last) <u>Thompson</u>	(Month) <u>9</u> (Day) <u>30</u> (Year) <u>1955</u>
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Married</u>	8. DATE OF BIRTH: <u>1/18/75</u>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Home</u>	9. AGE last birthday: <u>80</u> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (State or foreign country): <u>Montgomery County, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Addison Dodd</u>		14. MOTHER'S MAIDEN NAME: <u>Jane Thompson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>unk</u> (If Yes, give war or dates of service) <u>✓</u>		16. SOCIAL SECURITY No.: <u>unk -</u>	
17. INFORMANT & ADDRESS: <u>Record, Springfield State Hospital</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
(a) Immediate cause <u>Pulmonary edema</u>		<u>minutes</u>
(b) Antecedent cause(s) <u>Asphyxiation</u>		<u>minutes</u>
(c) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last <u>Aspiration of curdled milk</u>		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Chronic brain syndrome associated with senile brain disease, with psychotic reaction</u>		<u>7 - 10 yrs.</u>
19a. DATE OF OPERATION: <u>2/3/55</u>	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21b. PLACE (Home, farm, factory, street, office bldg., etc.) <u>nursing home</u>	21c. (City or town) (County) <u>(06)</u> (State) <u>Maryland</u>
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>6 28 55 ? M.</u>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Fall - history indefinite</u>
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
SIGNATURE <u>James J. Tharrah</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>9/30/55</u>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF <u>Oct. 3, 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Heelville Cent</u>
LOCATION (City, town, or county) (State) <u>Heelville Maryland</u>	24. FUNERAL DIRECTOR <u>Roy W. Barber, Laytonsville Md.</u>	ADDRESS <u>Box Francis H Barber</u>
DATE REC'D BY LOCAL REG. <u>Sept. 30, 1955</u>	REGISTRAR'S SIGNATURE <u>C. Harry Eber</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

OCT 5 1955

RECEIVED

8577

## CERTIFICATE OF DEATH

Reg. Dist. No. 14

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Carroll</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> TOWN <u>Sykesville</u>	LENGTH OF STAY (in this place) <u>6 weeks</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore -12</u>	<u>3Y01-4</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>90 Grand View Mansion Springfield Rd. Rt. 32</u>	STREET ADDRESS (If rural give location) <u>5700 Loch Raven Blvd.</u>		
3. NAME OF DECEASED: (First) (Middle) (Last) <u>MARGARET</u> <u>TOEPFER</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Sept. 9. 1955</u> <u>19</u>	
5. SEX: <u>female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widowed</u>	8. DATE OF BIRTH: <u>Feb. 29. 1872</u>
9. AGE last birthday <u>83 yrs</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Home</u>	11. BIRTHPLACE (State or foreign country): <u>Baltimore Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME: <u>? Heinz</u>	
14. MOTHER'S MAIDEN NAME: <u>Amanda Palmer</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS: <u>Mr. &amp; Mrs. F. Paul Dwyer (daughter)</u> <u>5700 Loch Raven Blvd. Baltimore</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>arteriosclerotic cardiovascular disease</u>			
ANTECEDENT CAUSE (S) (B) <u>with chronic myocarditis &amp; hypertension</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>9 Sept. 1955</u> , 19 <u>55</u> , to <u>12.50 P.M.</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>9 Sept. 1955</u> , and that death occurred at <u>12.50 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>G. H. Lawrence</u>		ADDRESS <u>Sykesville, Md.</u> DATE SIGNED <u>9 September 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Sept. 12. 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Sept. 10, 1955</u>		REGISTRAR'S SIGNATURE <u>C. Harry Edger</u>	
24. FUNERAL DIRECTOR <u>North Ave. &amp; Broadway</u>		ADDRESS <u>Baltimore, Md.</u>	

MARGIN RESERVED FOR BINDING

RECEIVED

SEP 13 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08581

8578

## CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Carroll</b>		MARYLAND		STATE <b>Maryland Carroll</b> COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Rural, Westminster</b>		LENGTH OF STAY (in this place) <b>20 Yrs.</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Rural, Westminster</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Manchester District Westminster, Md. R.D.3</b>				STREET ADDRESS <b>Manchester District Westminster, Md. R.D.3</b>			
3. NAME OF DECEASED: (First) (Middle) (Last) <b>Emma Missouri Wentz</b>				4. DATE OF DEATH: (Month) (Day) (Year) <b>9/29/55 19</b>			
5. SEX: <b>Female</b>	6. COLOR OR RACE: <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	8. DATE OF BIRTH: <b>5/16/1871</b>	9. AGE last birthday: <b>84</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life. <b>Housewife, Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY: <b>Own home</b>		11. BIRTHPLACE (State or foreign country): <b>Carroll Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME: <b>Lewis D. Leese</b>				14. MOTHER'S MAIDEN NAME: <b>Ellen Fridinger</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>No. 4</b>		16. SOCIAL SECURITY No.: <b>None</b>		17. INFORMANT & ADDRESS: <b>O.E. Wentz R. D. 3, Westminster, Md.</b>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <b>420.0 Immediate cause</b>				Interval Between Onset And Death <b>Anterosclerotic Heart Disease 5 yrs.</b>			
(a) DUE TO							
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.				(b) DUE TO			
(c)							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: <b>0</b>				19b. MAJOR FINDINGS OF OPERATION			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Sept 1952</b> to <b>Oct 29</b> , 1955, that I last saw the deceased alive on <b>Oct 26</b> , 1955, and that death occurred at <b>9:30 AM</b> , from the causes and on the date stated above.							
SIGNATURE <b>W. N. Hoard</b>		(Degree or title)		ADDRESS <b>Manchester, Md.</b>		DATE/SIGNED <b>9/29/55</b>	
23. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		DATE THEREOF <b>10/2/55</b>		NAME OF CEMETERY OR CREMATORY <b>Bachmans Valley Cemetery</b>		LOCATION (City, town, or county) (State) <b>Manchester Dist., Carroll Co. Md.</b>	
DATE REC'D BY LOCAL REGISTRAR <b>Sept 29-55</b>		REGISTRAR'S SIGNATURE <b>Mrs. H. P. Deener</b>		24. FUNERAL DIRECTOR <b>John Little &amp; Son</b>		ADDRESS <b>Littlestown, Pa.</b>	
<b>Ray B. A. Little</b>							

BUREAU V. 1

SEP 30 1955

RECEIVED

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist.

No. 26

## 1. PLACE OF DEATH:

COUNTY Carroll MARYLAND  
 CITY (If outside corporate limits, write RURAL OR and give nearest town)  
 TOWN Westminster LENGTH OF STAY (in this place) 25 years  
 HOSPITAL OR INSTITUTION OR STREET ADDRESS Cr. Madonna & George St.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Carroll  
 CITY (If outside corporate limits write RURAL and give nearest town)  
 TOWN Westminster 27  
 STREET ADDRESS (If rural, give location) 58 Madonna St.

3. NAME OF DECEASED: (First) (Middle) (Last)  
 (Type or Print) REUBEN BURBESS WILLIAMS

4. DATE OF DEATH (Month) (Day) (Year)  
Sept. 7 1955

5. SEX M 6. COLOR OR RACE White 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married 8. DATE OF BIRTH: Dec. 16, 1890 9. AGE last birthday: 64 yrs. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Garage Wrecker, City of Westminster, Md. 10b. KIND OF BUSINESS OR INDUSTRY: Carroll Co. Md. 11. BIRTHPLACE (State or foreign country): U.S.A. 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT &amp; ADDRESS:

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause

(a) Strangling by the neck

DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH

## II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☒21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY at work)

21c. (City or town)

(County)

(State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 9 7 55 M.21e. INJURY OCCURRED While at work ☐ Not while at work ☒21f. HOW DID INJURY OCCUR? Strangling

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

SIGNATURE

James J. Thorne

CHIEF MEDICAL EXAMINER ☐ DATE SIGNED 9/12/55  
 DEPUTY MEDICAL EXAMINER ☒  
 ASSISTANT MEDICAL EXAM. ☐

M. D.

23. BURIAL, CREMATION, REMOVAL (Specify):

DATE REC'D BY LOCAL REG.

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

9-13-55Harriet MuellerJ. E. Rogers, Jr., Westminster, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

NATIONAL BUREAU OF HEALTH SERVICES

BUREAU V. 8

SEP 14 1955

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH

08583

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 70

8579

1. PLACE OF DEATH- COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>Maryland</b> COUNTY <b>Carroll</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Taneytown</b>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Taneytown</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>life</b>		STREET ADDRESS (If rural, give location) <b>/</b>	
3. NAME OF DECEASED (Type or Print)	(First) <b>Mary</b>	(Middle) <b>Blanche</b>	(Last) <b>Wilt</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Widow</b>	8. DATE OF BIRTH <b>Sept. 23, 1888</b>
9. AGE last birthday <b>66</b> yrs.		4. DATE OF DEATH <b>September 20 1955</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jesse Leister</b>		14. MOTHER'S MAIDEN NAME <b>Cora Lawyer</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT AND ADDRESS <b>Mrs. James Baumgardner, Taneytown, Md.</b>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(a) <b>Intestinal Obstruction</b>		<b>15 days</b>	
(b) <b>Carcinoma of uterus</b>		<b>12 mo</b>	
(c) <b>Hypertension - nitral Regurgitation</b>		<b>many years</b>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Sept 1</b> , 19 <b>55</b> , to <b>Sept 20</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>Sept 19</b> , 19 <b>55</b> , and that death occurred at <b>1:40 A</b> m., from the causes and on the date stated above.			
SIGNATURE <b>E. Quibler Thompson</b>		ADDRESS <b>M.D. Taneytown Md.</b>	
DATE SIGNED <b>9-21-55</b>			
23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		DATE THEREOF <b>Sept. 22, 1955</b>	
NAME OF CEMETERY OR CREMATORY <b>Lutheran Cemetery</b>		LOCATION (City, town, or county) (State) <b>Taneytown, Maryland</b>	
DATE REC'D BY LOCAL REG. <b>Sept 21, 1955</b>		REGISTRAR'S SIGNATURE <b>Ethel M. Mehling</b>	
24. FUNERAL DIRECTOR <b>C.O. Fuss &amp; Son, Taneytown, Maryland</b>		ADDRESS	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

SEP 23 1955

RECEIVED

8580

08584

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist.

No. 74

## I. PLACE OF DEATH:

COUNTY **Carroll** MARYLAND  
 CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN **Route 140, Sandymount Road**  
 HOSPITAL OR INSTITUTION OR STREET ADDRESS

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE **Maryland** COUNTY **Carroll**  
 CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN **Baltimore**  
 STREET ADDRESS (If rural, give location)  
**2008 Barclay Street**

3. NAME OF DECEASED: (First) (Middle) (Last)  
 (Type or Print) **NATHAN A. WOLF**

4. DATE OF DEATH (Month) (Day) (Year)  
**9/18/55** 19

5. SEX: **Male** 6. COLOR OR RACE: **White** 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH: **1892** 9. AGE last birthday: **63** yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): **Proprietor** 10b. KIND OF BUSINESS OR INDUSTRY: **Procter**

11. BIRTHPLACE (State or foreign country): **Russia** 12. CITIZEN OF WHAT COUNTRY? **RUSA**

13. FATHER'S NAME:

**Jacob Wolf**

14. MOTHER'S MAIDEN NAME:

**Fannie**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT &amp; ADDRESS:

**Mr. Edward Legum - 3026 Troja Parkway**

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause

(a) **Crushed chest**

DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)

INTERVAL BETWEEN ONSET AND DEATH

## II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY **street**

21c. (City or town) (County) (State) **Sandymount Rd. Carroll Maryland**

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY **9/18/55 6:40 P.M.**

21e. INJURY OCCURRED While at work ☐ Not while at work ☒

21f. HOW DID INJURY OCCUR? **Auto-tractor-trailer collision.**

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

**William A. [Signature]**

CHIEF MEDICAL EXAMINER ☐ DATE SIGNED  
 DEPUTY MEDICAL EXAMINER ☒ 9/19/55  
 M. D. ASSISTANT MEDICAL EXAM.

23. BURIAL, CREMATION, REMOVAL (Specify):

**Burial**

DATE THEREOF

**Sept. 20/55**

NAME OF CEMETERY OR CREMATORY

**Anole Respa**

LOCATION (City, town, or county)

**Rosedale, Md**

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

**[Signature]**

24. FUNERAL DIRECTOR

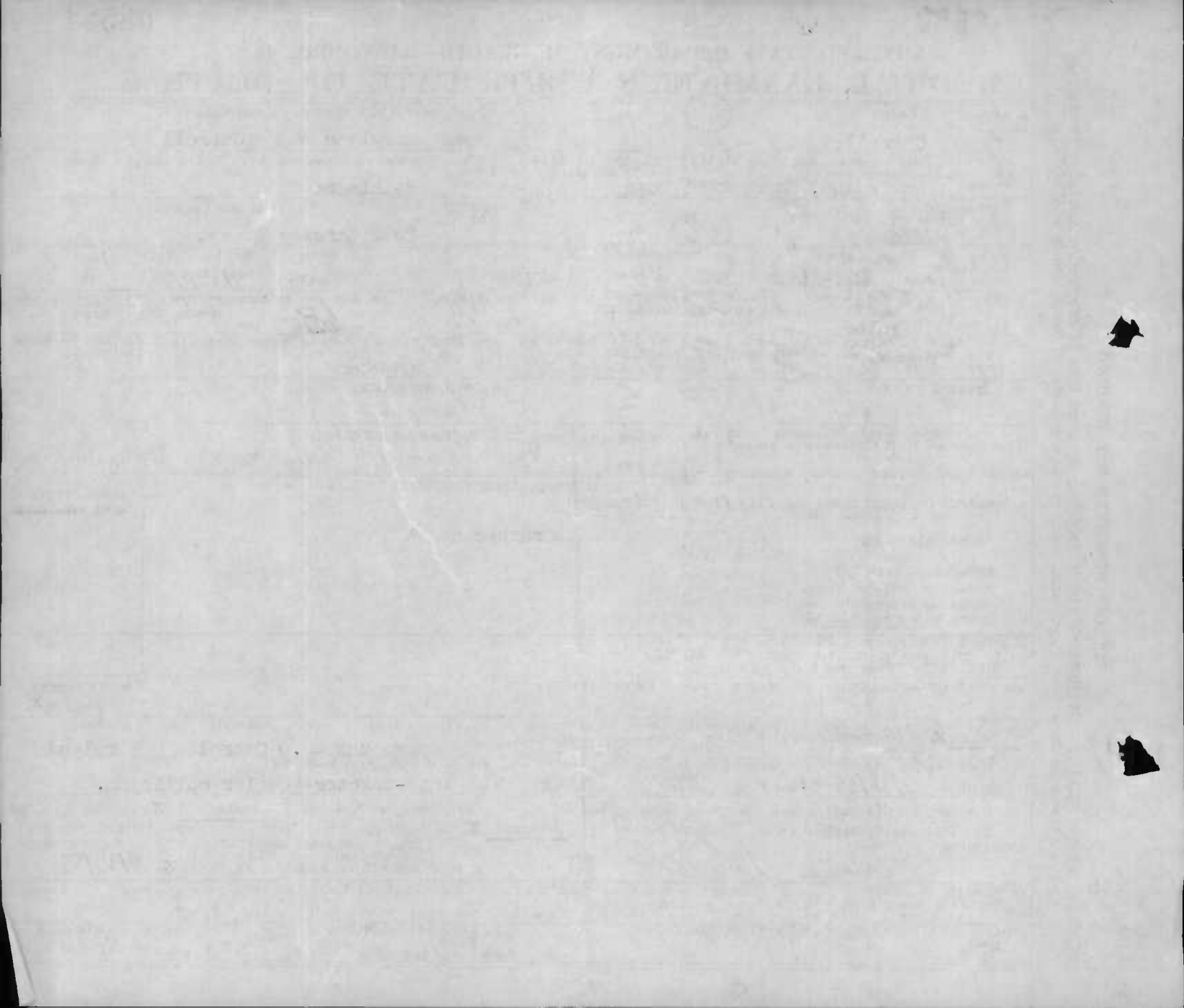
**Sol. Johnson & Sons**

ADDRESS

**-1124-26 W. North Ave**

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



8525

## CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Westminster</u>		LENGTH OF STAY (in this place) <u>30 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Westminster, Md.</u>		<u>27</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>66 Penna. Ave</u>				STREET ADDRESS (If rural give location) <u>66 Penna. Ave.</u>		<u>1</u>	
3. NAME OF DECEASED: (First) <u>Agnes</u> (Middle) <u>Sarah</u> (Last) <u>Youngling</u>				4. DATE OF DEATH: (Month) <u>Sept</u> (Day) <u>17</u> (Year) <u>1955</u>			
5. SEX: <u>F.</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>		8. DATE OF BIRTH: <u>Jan. 15, 1865</u>	
9. AGE last birthday: <u>90</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY: <u>Housewife</u>		11. BIRTHPLACE (State or foreign country): <u>Carroll Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>George W. Babylon</u>				14. MOTHER'S MAIDEN NAME: <u>Fannie Galle</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY No.: <u>—</u>		17. INFORMANT & ADDRESS: <u>Wm. B. Youngling, Westminster Md.</u>	
18. MEDICAL CERTIFICATION						Interval Between Onset and Death	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
Immediate cause <u>331X</u> <u>Acute Cerebral hemorrhage</u>						<u>18 hours</u>	
Antecedent causes (s) <u>General Arterio-Sclerosis</u>						<u>10 years</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.							
11. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: <u>9</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9/17</u> , 19 <u>55</u> , to <u>9/17</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>9/17</u> , 19 <u>55</u> , and that death occurred at <u>11:45 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Arthur Barr</u>		ADDRESS <u>Westminster, Md.</u>		DATE SIGNED <u>9/19/55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Sept. 20, 55</u>		NAME OF CEMETERY OR CREMATORY <u>Pipe Creek Cemetery</u>		LOCATION (City, town, or county) (State) <u>Rural, Westminster, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>9-19-55</u>		REGISTRAR'S SIGNATURE <u>Harriet Muth</u>		24. FUNERAL DIRECTOR <u>J. E. Myers &amp; Co.</u>		ADDRESS <u>Westminster, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

252

BUREAU V. S.

SEP 21 1955

RECEIVED

08586

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

8581

## CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH- COUNTY <u>Cannell</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u> TOWN <u>Manchester</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>106 Westminster Ave</u>		MARYLAND LENGTH OF STAY (in this place) <u>50 years</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>md</u> COUNTY <u>Cannell</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u> TOWN <u>Manchester</u> STREET ADDRESS (If rural, give location) <u>106 Westminster Ave</u>	
3. NAME OF DECEASED (Type or Print) <u>David</u> (First) <u>Yingling</u> (Last) <u>Yingling</u>		4. DATE OF DEATH <u>Sept 24</u> (Month) (Day) (Year) <u>1955</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>6/30/73</u>	9. AGE last birthday <u>82</u> yrs.	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Transportation</u>		11. BIRTHPLACE (State or foreign country) <u>Cannell Co md</u>	
13. FATHER'S NAME <u>David Yingling</u>		14. MOTHER'S MAIDEN NAME <u>Clara Summel</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>none</u>		17. INFORMANT AND ADDRESS <u>Genie M Yingling 106 Westminster</u>	
18. MEDICAL CERTIFICATION					
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>420.1</u> Immediate cause (a) <u>Coronary Thrombosis</u> Antecedent cause(s) (b) <u>Arteriosclerosis</u> Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c)				INTERVAL BETWEEN ONSET AND DEATH <u>1 MON.</u> <u>5 yrs</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While at work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Oct</u> , 1947, to <u>Sept 24</u> , 1955, that I last saw the deceased alive on <u>Sept 20</u> , 1955, and that death occurred at <u>5:30 A</u> m., from the causes and on the date stated above.					
SIGNATURE <u>W.H. Froard</u>		(Degree or title) <u>M.D.</u>		ADDRESS <u>Manchester, Md</u> DATE SIGNED <u>9/24/55</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>9/26/55</u>		NAME OF CEMETERY OR CREMATORY <u>Manchester Ref Cem</u> LOCATION (City, town, or county) (State) <u>Manchester, Cannell md</u>	
DATE REC'D BY LOCAL REG <u>Sept 26-55</u>		REGISTRAR'S SIGNATURE <u>Mrs. W.P. Deumer</u>		FEDERAL DIRECTOR ADDRESS <u>Frederick Buckner Hanover Pa</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. L.

SEP 30 1955

RECEIVED